Financial Inputs

03/29/2016

Input Forms AS-I-010 Adult Care Residence Eligibility Communication Document

General Information

Adult Care Residence Eligibility Communication Document is a jointly owned form between DMAS and DSS. It does not currently have a form number. This form is a communication tool between the Local Department of Social Services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the Adult Care Residence (ACR) resident, and DMAS. This form is completed: 1) By the assessor/case manager to the eligibility worker and to DMAS at the time of a 12-month reassessment - a finding that the resident continues to meet either residential or assisted living is required in order for the eligibility worker to re-determine eligibility for an Auxiliary Grant (AG) payment; 2) By either the assessor/case manager or eligibility worker to the other and to DMAS whenever either becomes aware of a change in address; and 3) By the eligibility worker to the ACR assessor/case manager and to DMAS whenever the AG is terminated.

Subsystem:	Financial
Source/Originator:	Screening Team
Frequency:	On-Demand
Estimated Volume:	3,935 Per Month Approx.
Programs:	Short Assessment or ACRR Inquiry/Update (AST015)
Proc/Screen ID:	AS-S-015, AS-S-020

Adult Care Residence Eligibility Communication Document (AS-I-010)

VIRGINIA DEPARTMENTS OF MEDICAL ASSISTANCE SERVICES/SOCIAL SERVICES
ADULT CARE RESIDENCE ELIGIBILITY COMMUNICATION DOCUMENT

To/From: Dept. of Social Services Eligibility Worker in _____
(City/County Responsible for Auxiliary Grant)

Address: _____

To/From: _____ *(ACR Assessor/Case Manager)*

Address: _____

(1) Assessor's provider #: _____

RESIDENT: _____ (2) **SSN:** _____

Medicaid #: _____

ACR: _____ **ACR Location:** _____

PURPOSE OF COMMUNICATION (check 1, 2, or 3):

____ 1. *ANNUAL REASSESSMENT COMPLETED* **Date of Reassessment:** ____/____/____

a. ____ ***Resident Continues to Meet Criteria for ACR Placement at the following level of care:***
___Residential Living ___Regular Assisted Living ___Intensive Assisted Living

For intensive assisted living residents:	Yes	No
• Continues to need intensive assisted living services:	____	____
• Based on UAI, continues to meet criteria for intensive assisted living	____	____

b. ____ ***Resident Does Not Meet Criteria for Residential or Assisted Living***

____ 2. *RESIDENT NO LONGER RESIDES IN ACR ON RECORD.* Resident has been discharged to:

a. ____ ***Another ACR.*** Last Date of Service in the ACR on Record: ____/____/____
Name of New ACR: _____
Provider #: _____ Start of Care Date in New ACR: ____/____/____
Address of New ACR: _____

b. ____ ***Home.*** Last Date of Service in the ACR: ____/____/____
New Address: _____

c. ____ ***Other*** (please specify): _____
Last Date of Service in the ACR: ____/____/____
New Address: _____

____ 3. *AUXILIARY GRANT ELIGIBILITY TERMINATED* Effective Date: ____/____/____
Reason: _____

(Name of Assessor/Case Manager Completing Form)		(Name of Eligibility Worker Completing Form)	
(Signature of Assessor/Case Manager Completing Form)		(Signature of Eligibility Worker Completing Form)	
(Date)	(Telephone No.)	(Date)	(Telephone No.)

Revised 5/98

Adult Care Residence Eligibility Communication Document (AS-I-010)

ACR ELIGIBILITY COMMUNICATION DOCUMENT INSTRUCTIONS

WHEN TO USE THIS FORM

This form is a communication tool between the local department of social services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the adult care residence (ACR) resident, and DMAS. This form is completed:

1. By the assessor/case manager to the eligibility worker and to DMAS at the time of a 12-month reassessment (a finding that the resident continues to meet either residential or assisted living is required in order for the eligibility worker to redetermine eligibility for an Auxiliary Grant (AG) payment);
2. By either the assessor/case manager or eligibility worker to the other and to DMAS whenever either becomes aware of a change in address; and
3. By the eligibility worker to the ACR assessor/case manager and to DMAS whenever the AG is terminated.

TO/FROM SECTION

Both TO/FROM sections must be completed. Completely fill in the locality of the DSS eligibility worker with address and indicate whether document is to be sent to or from the eligibility worker by circling "TO" or "FROM." In the second TO/FROM section, completely fill in the assessor or case manager's name, address and provider number and indicate whether the document is to be sent to or from the assessor or case manager by circling "TO" or "FROM."

RESIDENT IDENTIFICATION SECTION

1. RESIDENT: Legibly print name of ACR resident who is being assessed, who has moved, or whose AG has been terminated.
2. SSN: Write in the resident's social security number. Record the resident's Medicaid number.
3. ACR: Legibly print the name of the ACR in which the resident resides.
4. ACR location: List the city/town in which the ACR is located.

PURPOSE OF COMMUNICATION SECTION: Check either 1., 2., or 3.

If 1. is checked (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. (Resident continues to meet criteria for ACR placement at the following level of care) or b. (Resident does not meet criteria for residential or assisted living. If a. is checked, indicate which level of care the individual meets. If intensive assisted living is checked, respond to the two questions in the gray box ("continues to need intensive assisted living services" and "based on the UAI, continues to meet criteria for intensive assisted living"). Usually, both will be checked "yes." When 1. is checked, the assessor sends a copy of the Uniform Assessment Instrument (UAI), the ACR Eligibility Communication Document (ECD), and the HCFA-1500 to DMAS. In addition, the assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ACR; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents.

NOTE: If a reassessment indicates a change in level of care, treat the assessment as a change in level of care. That is, send a copy of the UAI and the DMAS-96 to DMAS. In addition, send the eligibility worker a copy of the DMAS-96; send to the ACR copies of the UAI, DMAS-96, and decision letter; and send a decision letter to the individual being assessed. The assessor should keep a copy of each.

If 2. is checked (Resident no longer resides in ACR on record), indicate to where the resident moved (i.e., another ACR, home, or other). For each, indicate the last date of service in the ACR on record. Complete other information such as new address, etc., if known. When 2. is checked, the assessor/case manager or eligibility worker completing the ECD should send a copy to the other and a copy to DMAS and keep a copy for him- or herself.

If 3. is checked (Auxiliary Grant Eligibility Terminated), the eligibility worker indicates the effective date of termination and the reason. Then the eligibility worker sends a copy of the ECD to the assessor/case manager and to DMAS.

SIGNATURES SECTION

For each form completed, only one signature section will be completed. For example, if an assessor is completing the form for a reassessment, the left-hand side with assessor information will be completed. If the eligibility worker is completing the form for notification of AG eligibility termination, then the right-hand side is completed. Please completely fill in the applicable section with printed name of individual completing the form, signature, complete date with month/day/year, and telephone number with area code.

Please photocopy this form as needed; plain paper copies are acceptable.

FOR ADDITIONAL INFORMATION, PLEASE REFER TO THE *ASSESSMENT AND TARGETED CASE MANAGEMENT SERVICES IN ADULT CARE RESIDENCES. PROCEDURES FOR ASSESSORS AND CASE MANAGERS.* THIS MANUAL IS AVAILABLE FROM THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES, ADULT SERVICES PROGRAM, AT 804-692-1299.

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Assessors Provider #	National Provider Identifier	DE4700

2	SSN	Person Social Security Number	DE1000

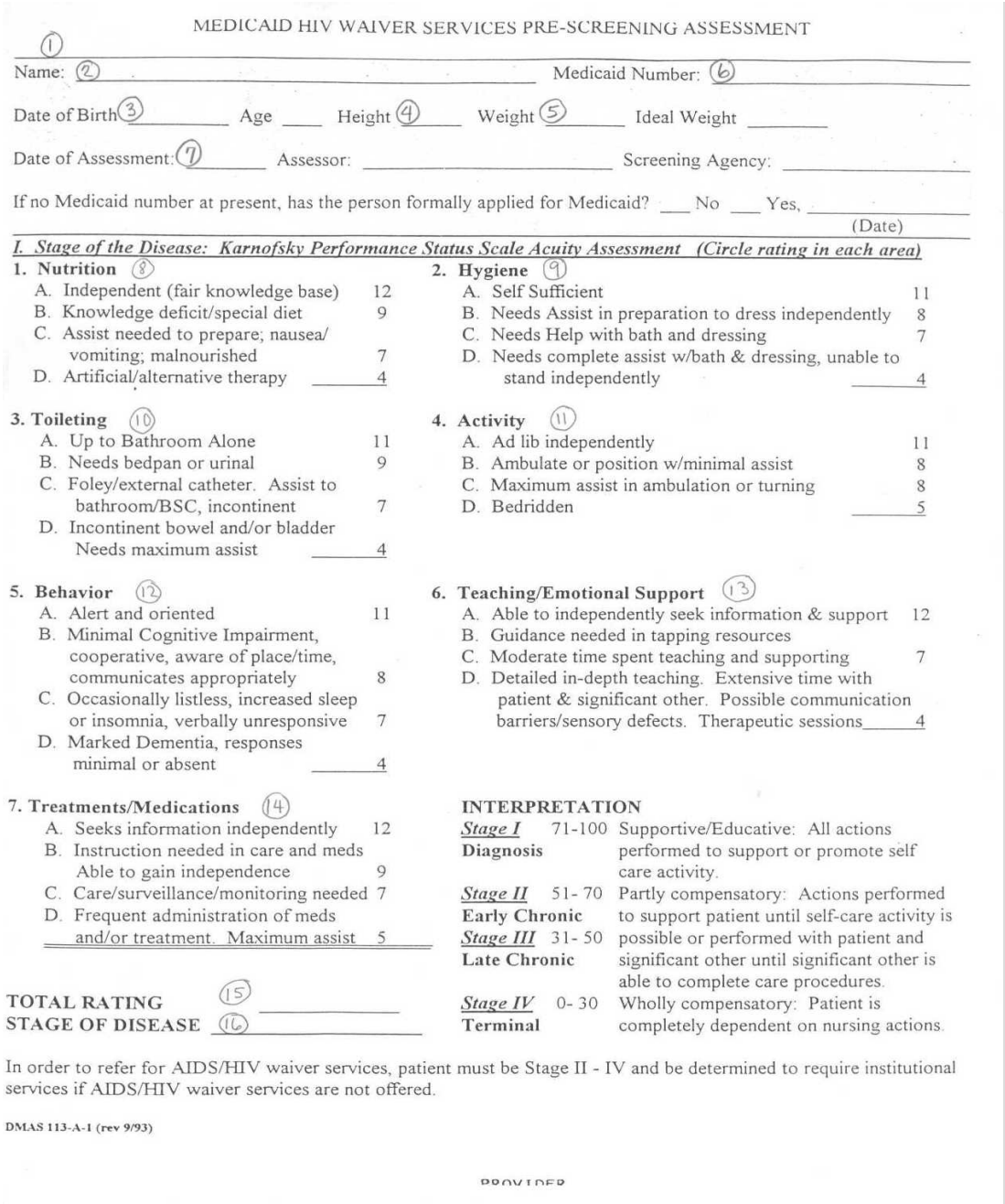
Input Forms AS-I-020 DMAS 113A - Medicaid HIV Waiver Services Pre-Screening Assessment

General Information

DMAS 113A is the Pre-Screening Assessment part of the Medicaid HIV Waiver Services form. It is always attached to a DMAS-96 for Aids Waiver Services. Effective 7/1/98 a UAI form is required to be submitted as a part of the HIV assessment packet. This form is used to assess the stage of the AIDS disease using the Karnofsky Performance Status Scale Acuity Assessment. In order to refer for AIDS/HIV waiver services, patient must be Stage II - IV and be determined to require institutional services if AIDS/HIV waiver services are not offered.

Subsystem:	Financial
Source/Originator:	Screening Team
Frequency:	On-Demand
Estimated Volume:	427 Per Month
Programs:	AIDS Waiver Inquiry/Update (AST040)
Proc/Screen ID:	AS-S-040
Graphics:	as i-020

DMAS 113A - Medicaid HIV Waiver Services Pre-Screening Assessment (AS-I-020)



MEDICAID HIV WAIVER SERVICES PRE-SCREENING ASSESSMENT

(1)

Name: (2) _____ Medicaid Number: (6) _____

Date of Birth (3) _____ Age ____ Height (4) _____ Weight (5) _____ Ideal Weight _____

Date of Assessment: (7) _____ Assessor: _____ Screening Agency: _____

If no Medicaid number at present, has the person formally applied for Medicaid? ___ No ___ Yes, _____ (Date)

I. Stage of the Disease: Karnofsky Performance Status Scale Acuity Assessment (Circle rating in each area)

1. Nutrition (8)
- A. Independent (fair knowledge base) 12
- B. Knowledge deficit/special diet 9
- C. Assist needed to prepare; nausea/ vomiting; malnourished 7
- D. Artificial/alternative therapy 4

2. Hygiene (9)
- A. Self Sufficient 11
- B. Needs Assist in preparation to dress independently 8
- C. Needs Help with bath and dressing 7
- D. Needs complete assist w/bath & dressing, unable to stand independently 4

3. Toileting (10)
- A. Up to Bathroom Alone 11
- B. Needs bedpan or urinal 9
- C. Foley/external catheter. Assist to bathroom/BSC, incontinent 7
- D. Incontinent bowel and/or bladder Needs maximum assist 4

4. Activity (11)
- A. Ad lib independently 11
- B. Ambulate or position w/minimal assist 8
- C. Maximum assist in ambulation or turning 8
- D. Bedridden 5

5. Behavior (12)
- A. Alert and oriented 11
- B. Minimal Cognitive Impairment, cooperative, aware of place/time, communicates appropriately 8
- C. Occasionally listless, increased sleep or insomnia, verbally unresponsive 7
- D. Marked Dementia, responses minimal or absent 4

6. Teaching/Emotional Support (13)
- A. Able to independently seek information & support 12
- B. Guidance needed in tapping resources
- C. Moderate time spent teaching and supporting 7
- D. Detailed in-depth teaching. Extensive time with patient & significant other. Possible communication barriers/sensory defects. Therapeutic sessions 4

7. Treatments/Medications (14)
- A. Seeks information independently 12
- B. Instruction needed in care and meds Able to gain independence 9
- C. Care/surveillance/monitoring needed 7
- D. Frequent administration of meds and/or treatment. Maximum assist 5

INTERPRETATION

Stage I **Diagnosis**	71-100	Supportive/Educative: All actions performed to support or promote self care activity.
Stage II **Early Chronic**	51- 70	Partly compensatory: Actions performed to support patient until self-care activity is
Stage III **Late Chronic**	31- 50	possible or performed with patient and significant other until significant other is able to complete care procedures.
Stage IV **Terminal**	0- 30	Wholly compensatory: Patient is completely dependent on nursing actions.

TOTAL RATING (15) _____

STAGE OF DISEASE (16) _____

In order to refer for AIDS/HIV waiver services, patient must be Stage II - IV and be determined to require institutional services if AIDS/HIV waiver services are not offered.

DMAS 113-A-1 (rev 9/93)

PROVIDER

Field Definitions

#	Field Name	Data Element Name	Element ID
1	(1st Blank Line Just Below Title Head-ing)	Person Address	DE1002
2	Name	Person Name	DE1001
3	Date of Birth	Person Birth Date	DE1006
4	Height	Assessment Patient's Height	DE1242

5	Weight	Assessment Patient's Weight	DE1243
6	Medicaid Number	Person Enrollee ID	DE1004
7	Date of Assessment	Assessment Date	DE1023
8	Nutrition	HIV Waiver Nutrition Rating Score	DE1166
9	Hygiene	HIV Waiver Hygiene Rating Score	DE1360
10	Toileting	HIV Waiver Toileting Rating Score	DE1361
11	Activity	HIV Waiver Activity Rating Score	DE1362
12	Behavior	HIV Waiver Behavior Rating Score	DE1363
13	Teaching / Emotional Support	HIV Waiver Teaching, Emotional Support Rating Score	DE1364
14	Treatments / Medications	HIV Waiver Treatments, Medications Rating Score	DE1365
15	Total Rating	HIV Waiver Rating Total Score	DE1366
16	Stage of Disease	HIV Waiver Stage of Disease	DE1367

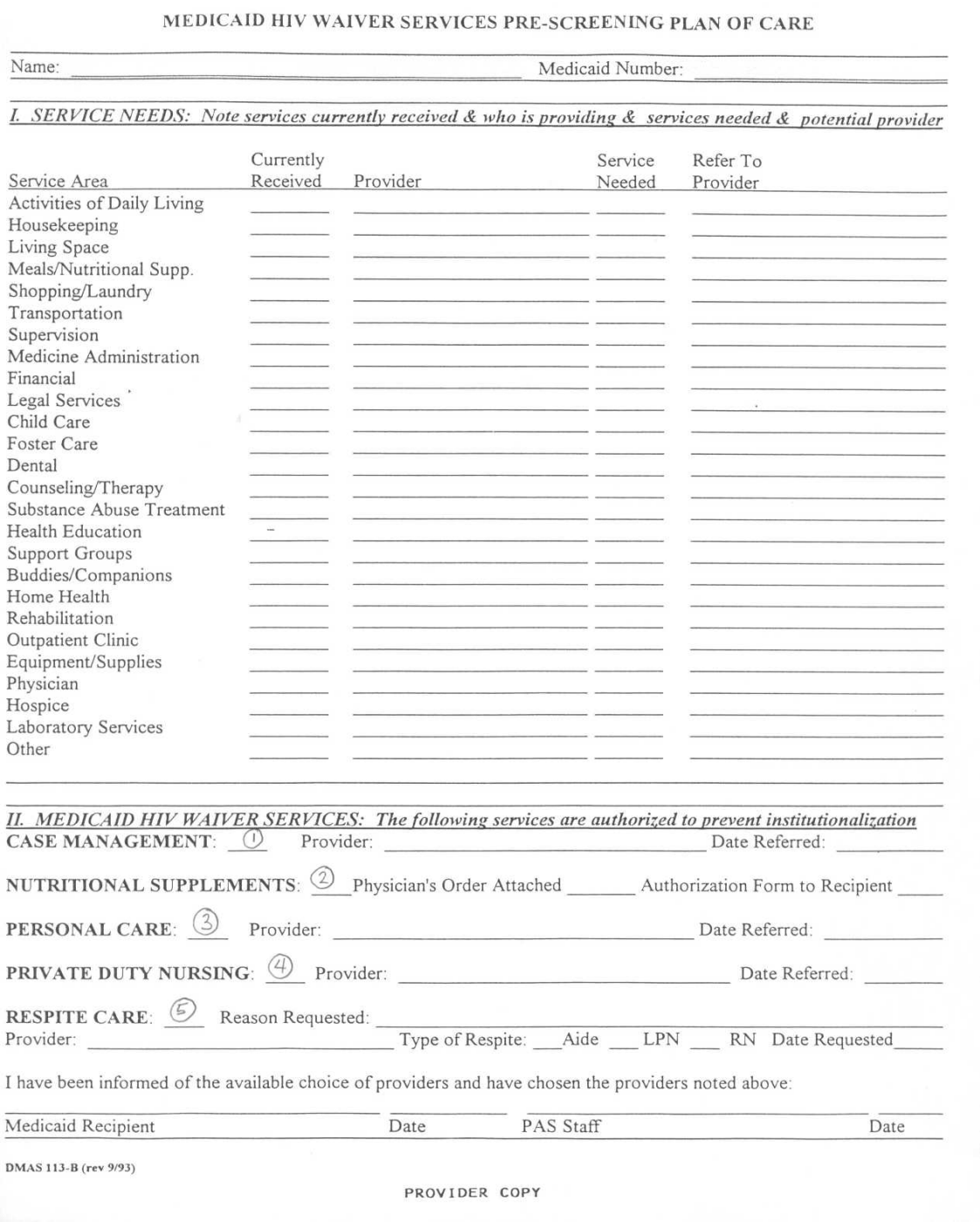
Input Forms AS-I-030 DMAS 113B - Medicaid HIV Waiver Services Pre-Screening Plan of Care

General Information

DMAS 113B is the Pre-Screening Plan of Care part of the Medicaid HIV Waiver Services form. It is always attached to a DMAS-96 for Aids Waiver Services. Effective 7/1/98 a UAI form is required to be submitted as a part of the HIV assessment packet. This form consists of two parts: 1) Service Needs - indicating services that are currently received, who is providing the service, the services needed, and name of the potential provider; and, 2) Medicaid HIV Waiver Services - indicating services that are authorized to prevent institutionalization.

Subsystem:	Financial
Source/Originator:	Screening Team
Frequency:	On-Demand
Estimated Volume:	427 Per Month
Programs:	AIDS Waiver Inquiry/Update (AST040)
Proc/Screen ID:	AS-S-040

DMAS 113B - Medicaid HIV Waiver Services Pre-Screening Plan of Care (AS-I-030)



MEDICAID HIV WAIVER SERVICES PRE-SCREENING PLAN OF CARE

Name: _____ Medicaid Number: _____

I. SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living				
Housekeeping				
Living Space				
Meals/Nutritional Supp.				
Shopping/Laundry				
Transportation				
Supervision				
Medicine Administration				
Financial				
Legal Services				
Child Care				
Foster Care				
Dental				
Counseling/Therapy				
Substance Abuse Treatment				
Health Education				
Support Groups				
Buddies/Companions				
Home Health				
Rehabilitation				
Outpatient Clinic				
Equipment/Supplies				
Physician				
Hospice				
Laboratory Services				
Other				

II. MEDICAID HIV WAIVER SERVICES: The following services are authorized to prevent institutionalization

CASE MANAGEMENT: (1) Provider: _____ Date Referred: _____

NUTRITIONAL SUPPLEMENTS: (2) Physician's Order Attached _____ Authorization Form to Recipient _____

PERSONAL CARE: (3) Provider: _____ Date Referred: _____

PRIVATE DUTY NURSING: (4) Provider: _____ Date Referred: _____

RESPITE CARE: (5) Reason Requested: _____
Provider: _____ Type of Respite: ___Aide ___ LPN ___ RN Date Requested_____

I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient _____ Date _____ PAS Staff _____ Date _____

DMAS 113-B (rev 9/93)

PROVIDER COPY

Field Definitions

#	Field Name	Data Element Name	Element ID
1	CASE MANAGEMENT	HIV Waiver Case Management Services Code	DE1384
2	NUTRITIONAL SUPPLEMENTS	HIV Waiver Nutritional Supplements	DE1368

		Services Code	
3	PERSONAL CARE	HIV Waiver Personal Care Services Code	DE1369
4	PRIVATE DUTY NURSING	HIV Waiver Private Duty Nursing Services Code	DE1370
5	RESPITE CARE	HIV Waiver Respite Care Services Code	DE1371

Input Forms AS-I-040 DMAS 80 - Patient Intensity Rating System Review (PIRSR)

General Information

DMAS-80 Virginia Department of Medical Assistance Services, Patient Intensity Rating System Review (PIRSR). This assessment form is submitted by Nursing Facilities in order to determine the facility's PIRS Rate. The form consists of five major parts including: 1) Identification Information; 2) Summary of Providers; 3) Medical Status; 4) Functioning Status; and, 5) Rehabilitation Services Currently Received.

Subsystem:	Financial
Source/Originator:	NH Servicing Provider
Frequency:	On-Demand
Estimated Volume:	3597 Per Month
Programs:	Level of Care Inquiry/Update (AST075)
Proc/Screen ID:	AS-S-010, AS-S-075

DMAS 80 - Patient Intensity Rating System Review (PIRSR) (AS-I-040)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PATIENT INTENSITY RATING SYSTEM REVIEW (PIRSR)

(1) Assessment Date: ___/___/___ (mo da yr)

(2) Reason for Submission: ☐ Admission ☐ Change from Specialized Care ☐ UR/PIRS ☐ 30-day Medicaid ineligibility

I. IDENTIFICATION INFORMATION

1. Resident Name: (3) _____ 2. Birthdate: (4) ___/___/___ (mo da yr) 3. Sex: ☐ Male$_0$ ☐ Female$_1$

4. Medicaid No: (5) _____-_____-_____-____ 5. Social Security No: (6) _____-_____-_____

II. SUMMARY OF PROVIDERS

	Provider Name	Location/Chain	Provider #	Dates of Admission	Dates of Discharge
6. Prior	a.				
	b.				
7. Current	(7)	(8)	(9)	(10)	(11)

8. **Current** Payment Source: (12) ☐ Nursing Facility/Medicaid only$_1$ ☐ Medicare/Medicaid Co-pay$_2$

III. MEDICAL STATUS

9. PARALYSIS/PARESIS (13) ☐ NONE$_{000}$

	LOCATION	PREVIOUS REHAB PROG. YES$_1$	PREVIOUS REHAB PROG. NO/NOT COMPL$_2$	ONSET MORE THAN 1 YR$_1$	ONSET 1 YR OR LESS$_2$
Monoplegia/ Paresis$_1$			–		
Hemiplegia/ Paresis$_2$					
Paraplegia/ Paresis$_3$					
Triplegia/ Paresis$_4$					
Bilateral Hemi-plegia/Paresis$_5$	//////// ////////				
Quadriplegia/ Paresis$_6$	//////// ////////				

10a. DIAGNOSES: **Enter codes for 3 primary active diagnoses on the lines below. If none apply, enter "00000".**

DX 1 (14) _____ DX 2 (15) 31900 DX 3 (16) _____

MENTAL RETARDATION (PASARR) ~~31000~~
ALCOHOLISM, SUBSTANCE ABUSE **30300**
RENAL FAILURE (end stage) **58500**
MUSCULOSKELETAL, GENL **71500**
SPINAL CORD INJURIES **95300**
BRAIN/SPINAL CORD/NERVES **78100**
MENTAL ILLNESS (PASARR) **29600**
RELATED MR CONDITIONS (PASARR) **34300**
SEIZURE DISORDER (NON-PASARR) **34500**
DEGENERATIVE NEURO DISEASE **34000**
PSYCHIATRIC, GENL (NON-PASARR) **30000**
DIGESTIVE/LIVER/GALL BLADDER **53700**
CANCER **19500**
HEART/CIRCULATION **41000**
TRAUMA TO THE BRAIN **85000**
ENDOCRINE, GENL **51900**
RESPIRATORY, GENL **49280**
ALZHEIMER'S **33100**
AIDS **04200**

10b. Joint Motion: (17)

☐ Within normal limits$_0$ ☐ Instability uncorrected$_3$
☐ Limited motion$_1$ ☐ Immobility$_4$
☐ Instability corrected$_2$

IV. FUNCTIONING STATUS (Check **ONE** box for each item)

11. Bathing: (18)
☐ Bathes independently or mechanical assistance only$_1$
☐ Bathes with some human assistance$_3$
☐ Is bathed by staff or does not bathe$_5$

12. Dressing: (19)
☐ Dresses independently or with mechanical assistance only$_1$
☐ Dresses with some human assistance$_3$
☐ Is dressed by staff or does not dress$_5$

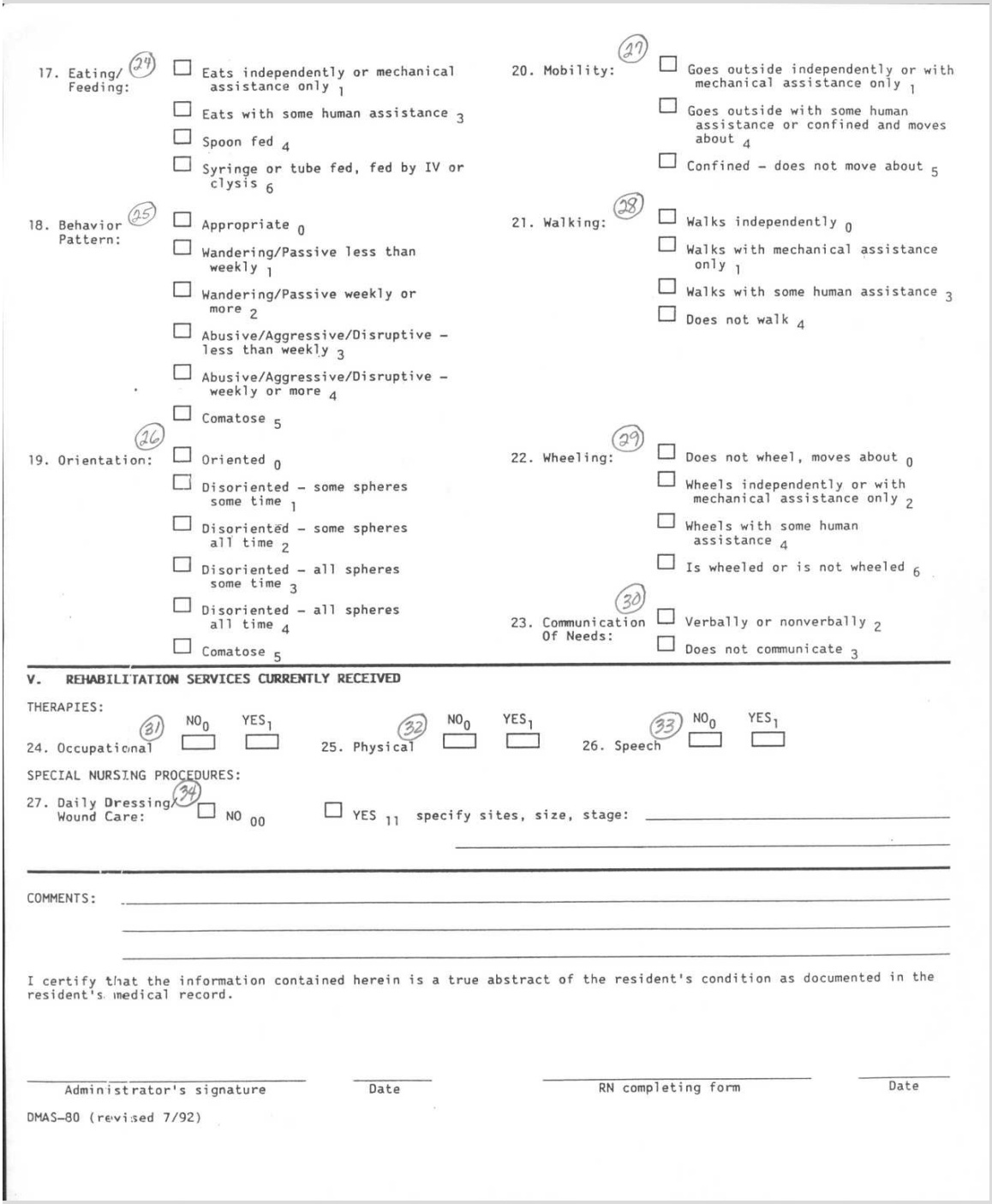
13. Toileting: (20)
☐ Toilets independently or with mechanical assistance only$_1$
☐ Toilets with some human assistance$_3$
☐ Does not use toilet room$_4$

14. Transferring: (21)
☐ Transfers independently or mechanical assistance only$_1$
☐ Transfers with some human assistance$_3$
☐ Is transferred$_4$
☐ Is not transferred$_5$

15. Bowel Function: (22)
☐ Continent, incontinent less than weekly, ostomy – self-care$_2$
☐ Incontinent weekly or more, other problems$_3$
☐ Ostomy – not self-care$_4$

16. Bladder Function: (23)
☐ Continent, incontinent less than weekly, devices w/self care$_4$
☐ Incontinent weekly or more$_5$
☐ Devices, not self care$_8$

DMAS 80 - Patient Intensity Rating System Review (PIRSR) (AS-I-040)



17. Eating/ Feeding: (24)
- ☐ Eats independently or mechanical assistance only 1
- ☐ Eats with some human assistance 3
- ☐ Spoon fed 4
- ☐ Syringe or tube fed, fed by IV or clysis 6

18. Behavior Pattern: (25)
- ☐ Appropriate 0
- ☐ Wandering/Passive less than weekly 1
- ☐ Wandering/Passive weekly or more 2
- ☐ Abusive/Aggressive/Disruptive – less than weekly 3
- ☐ Abusive/Aggressive/Disruptive – weekly or more 4
- ☐ Comatose 5

19. Orientation: (26)
- ☐ Oriented 0
- ☐ Disoriented – some spheres some time 1
- ☐ Disoriented – some spheres all time 2
- ☐ Disoriented – all spheres some time 3
- ☐ Disoriented – all spheres all time 4
- ☐ Comatose 5

20. Mobility: (27)
- ☐ Goes outside independently or with mechanical assistance only 1
- ☐ Goes outside with some human assistance or confined and moves about 4
- ☐ Confined – does not move about 5

21. Walking: (28)
- ☐ Walks independently 0
- ☐ Walks with mechanical assistance only 1
- ☐ Walks with some human assistance 3
- ☐ Does not walk 4

22. Wheeling: (29)
- ☐ Does not wheel, moves about 0
- ☐ Wheels independently or with mechanical assistance only 2
- ☐ Wheels with some human assistance 4
- ☐ Is wheeled or is not wheeled 6

23. Communication Of Needs: (30)
- ☐ Verbally or nonverbally 2
- ☐ Does not communicate 3

V. REHABILITATION SERVICES CURRENTLY RECEIVED

THERAPIES:

24. Occupational (31) NO 0 ☐ YES 1 ☐
25. Physical (32) NO 0 ☐ YES 1 ☐
26. Speech (33) NO 0 ☐ YES 1 ☐

SPECIAL NURSING PROCEDURES:

27. Daily Dressing/ Wound Care: (34) ☐ NO 00 ☐ YES 11 specify sites, size, stage: _____

COMMENTS: _____

I certify that the information contained herein is a true abstract of the resident's condition as documented in the resident's medical record.

Administrator's signature _____ Date _____ RN completing form _____ Date _____

DMAS–80 (revised 7/92)

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Assessment Date	Assessment Date	DE1023

2	Reason for Submission	Assessment Source Code	DE1022
3	Resident Name	Person Name	DE1001
4	Birthdate	Person Birth Date	DE1006
5	Medicaid No	Person Enrollee ID	DE1004
6	Social Security No	Person Social Security Number	DE1000
7	Current Provider Name	Person Address	DE1002
8	Current Location/Chain	Person Address	DE1002
9	Current Provider #	National Provider Identifier	DE4700
10	Current Dates of Admission	PIRS Patient's Admission Date	DE1042
11	Current Dates of Discharge	PIRS Patient's Discharge Date	DE1043
12	Current Payment Source	Benefit Plan Exception Indicator	DE3072
13	Paralysis/Paresis	PIRS Medical Status - Paralysis/Paresis Code	DE1054
14	Diagnosis: DX 1	PIRS Medical Diagnosis Code	DE1055
15	Diagnosis: DX 2	PIRS Medical Diagnosis Code	DE1055
16	Diagnosis: DX 3	PIRS Medical Diagnosis Code	DE1055
17	Joint Motion	PIRS Medical Status - Joint Motion Code	DE1073
18	Bathing	PIRS Function Status - Bath Code	DE1080
19	Dressing	PIRS Function Status - Dressing Code	DE1081
20	Toileting	PIRS Function Status - Toilet Code	DE1082
21	Transferring	PIRS Function Status - Transfer Code	DE1083
22	Bowel Function	PIRS Function Status - Bowel Code	DE1084
23	Bladder Function	PIRS Function Status - Bladder Code	DE1085
24	Eating/Feeding	PIRS Function Status - Eating/Feeding Code	DE1086
25	Behavior Pattern	PIRS Function Status - Behavior Code	DE1087
26	Orientation	PIRS Function Status - Orientation Code	DE1088
27	Mobility	PIRS Function Status - Mobility Level Code	DE1089
28	Walking	PIRS Function Status - Walking Code	DE1090
29	Wheeling	PIRS Function Status - Wheeling Code	DE1091
30	Communication of Needs	PIRS Function Status - Communications Code	DE1093

31	Therapies: Occupational	PIRS Current Service - Occupational Therapy Code	DE1101
32	Therapies: Physical	PIRS Current Service - Physical Therapy Code	DE1102
33	Therapies: Speech	PIRS Current Service - Speech Therapy Code	DE1103
34	Daily Dressing/Wound Care	PIRS Current Service - Daily Dressing Code	DE1116

Input Forms AS-I-050 DMAS 95 - MI/MR Supplemental Level I

General Information

This form has two parts: Part A is to be completed by the Nursing Home Pre-admission Screening Committee and Part B is to be completed by the Community Services Board or other entity under contract for Level II evaluation process. MI/MR Level II Form is used to gather additional information about a potential participant's mental capacity. This is considered a Level II Assessment and is indicated by the Medicaid Authorization Code and Level II Assessment Determination Code that can be found on the DMAS-96 form.

Subsystem:	Financial
Source/Originator:	Screening Team
Frequency:	On-Demand
Estimated Volume:	427 Per Month
Programs:	Short Assessment or ACRR Inquiry/Update (AST015) Full Assessment - Page 1 Inquiry/Update (AST025)
Proc/Screen ID:	AS-S-015, AS-S-020, AS-S-025, AS-S-030, AS-S-035

DMAS 95 - MI/MR Supplemental Level I (AS-I-050)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES MI/MR SUPPLEMENT LEVEL I

A. This section is to be completed by the Nursing Home Preadmission Screening Committee.

Name _____ Date of Birth _____ Date NHPAS Request Received _____
Social Security Number _____ Medicaid Number _____ Responsible CSB _____

1. **DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?** ____ yes ____ no (If "yes", this form must be completed. If "no", do not complete Level I screening and do not refer for Level II evaluation. Individual cannot be admitted to a Medicaid-enrolled nursing facility.)

2. **DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)?** ____ **yes** (☑ "yes" **only** if a. b. **and** c below are checked "yes") ____ **no** (If "no", do not refer for Level II PAS for MI) Diagnosis: _____

   a. Is this major mental disorder diagnosable under DSM-III-R (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)?
   _____ yes _____ no

   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? _____ yes _____ no

   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? _____ yes _____ no

3. **DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR) WHICH WAS MANIFESTED BEFORE AGE 18?**
   _____ yes _____ no

4. **DOES THE INDIVIDUAL HAVE A RELATED CONDITION?** **_____ yes** (☑ "yes" **only** if each item below is checked "yes") **_____ no** (If "no", do not refer for Level II PAS for related condition)

   a. Is the condition attributable to any other condition (e.g., cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment or services similar to those for these persons?
   _____ yes _____ no

   b. Has the condition manifested before age 22? _____ yes _____ no

   c. Is the condition likely to continue indefinitely? _____ yes _____ no

   d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity (circle applicable areas): self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living? _____ yes _____ no

5. **RECOMMENDATION (Either "a" or "b" MUST be checked.)**

   a. ☐ **Refer for Level II assessment for:**
   (1) ____ **MI** (#2 above is checked "yes")
   ____ **MR or Related Condition** (#3 or #4 is checked "yes")
   ____ **Dual diagnosis** (MI and MR/Related Condition categories are checked)
   NOTE: If 5a is checked, the individual may NOT be admitted to a nursing facility until the State Mental Health/Mental Retardation Authority has provided written approval that the individual's needs can be met in the nursing facility.

   Date Referral Package Sent: _____ CSB/Agency Pkg. Sent To: _____
   Contact Person: _____ Address: _____ Phone #: _____

   b. ☐ **No referral for Level II needed because individual:**
   ____ Does not meet the applicable criteria for serious MI or MR or related condition
   ____ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR
   ____ Has a primary diagnosis of dementia (including Alzheimer's disease) **AND** has a secondary diagnosis of a serious MI
   ____ Has a severe physical illness (e.g., documented evidence of coma, functioning at brain-stem level, or other conditions which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services)
   ____ Is terminally ill (note: a physician must have documented that individual's life expectancy is less than 6 months)

_____ _____ _____
Signature Title Screening Committee

_____ _____ _____
Date Telephone Number Street Address

(1)

DMAS 95 - MI/MR Supplemental Level I (AS-I-050)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MI/MR SUPPLEMENT: LEVEL II

Name _____ Screening Placement Recommendation _____

B. This section is to be completed by the Community Services Board or other entity under contract for Level II evaluation process.

1. **EVALUATIONS REQUIRED UPON RECEIPT OF REFERRAL** (Check evaluations submitted upon receipt of referral.)

___ Neurological Evaluation
___ Psychological Assessment
___ Psychiatric Assessment
___ Psychosocial/Funtional Assessment
___ History and Physical Examination
___ Other (please specify) _____

2. **RECOMMENDATION**

___ Specialized services are not indicated.

___ Specialized services are indicated.

Comments: _____

3. **Date referral package received:** _____ **Date package sent to DMHMRSAS:** _____

QMHP Signature (MI diagnosis)	Date	Telephone Number
Psychologist Signature (MR diagnosis)	Date	Telephone Number
Case Manager Signature/Title	Date	Telephone Number
Agency/Facility Name		Agency/Facility ID# (if applicable)
Mailing Address		

C. THIS SECTION IS TO BE COMPLETED ONLY BY THE THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES.

Date referral package received: _____ **Concur with recommendations of specialized services?** ____ **yes** ____ **no**

Comments: _____

Copies of referral package sent to:	Representative's Name:	Date Package Sent:
___ PAS representative		
___ Community Services Board		
___ Admitting/retaining nursing facility		
___ Discharging hospital (if applicable)		
___ Individual being evaluated*		
___ Individual's family		
___ Individual's legal representative (if any)*		
___ Attending physician		

*Appeals information included.

Signature of State MH/MRA	Title	Date	Telephone Number

DMAS 95 - MI/MR Supplemental Level I (AS-I-050)

MR/MR SUPPLEMENT INSTRUCTIONS

IDENTIFYING DATA

NAME: Last, first, and middle. **DATE OF BIRTH:** Month, date, and year.
SOCIAL SECURITY NUMBER: 9-digit number assigned. **MEDICAID NUMBER:** 12-digit benefit number assigned.
RESPONSIBLE CSB: The Community Services Board in the locality in which the individual resides.
DATE NHPAS REQUEST RECEIVED: The date that a request for a Level I screening was made.

1. Indicate whether the individual meets nursing facility criteria as described in the Virginia Medicaid Nursing rHome or Preadmission Screening Manuals. If "yes" is checked, complete the screening. If the individual does NOT meet nursing facility criteria, do not complete Level I screening and do not refer for Level II evaluation. If criteria is not met, the individual cannot be admitted to a nursing facility.

2. **Determination of Serious Mental Illness (MI):** Check "yes" (that the individual has a current diagnosis of serious MI) only if 2. a., b., and c. are checked "yes". Indicate the diagnosis if "yes" is checked. If "no" is checked for either a., b., or c. below, do not refer for Level II for MI.

   a. Check "yes" if the individual has a major mental disorder diagnosable under DSM-III-R (e.g., schizophrenia (including disorganized, catatonic, and paranoid types); mood (including bipolar disorder (mixed, manic, depressed, seasonal, NOS); major depression (single episode/recurrent, chronic, melancholic or seasonal), depressive disorder NOS; cyclothymia; dysthymia (primary/secondary or early/late onset); paranoid (including delusional, erotomanic, grandiose, jealous, persecutory, somatic, unspecified, or induced psychotic disorder); panic or other severe anxiety disorder (including panic disorder with agoraphobia, agoraphobia with or without history of panic disorder, social phobia, generalized anxiety disorder, obsessive compulsive disorder, past-traumatic stress disorder); somatoform disorder (includes somatization disorder, conversion disorder, somatoform pain disorder, hypochondriasis, body dysmorphic disorder, undifferentiated somatoform disorder, somatoform disorder NOS); personality disorder (includes paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, obsessive compulsive, passive aggressive, and NOS); other psychotic disorder (includes schizophreniform disorder, schizoaffective disorder (bipolar/depressive), brief reactive psychosis, atypical, NOS); or other mental disorder that may lead to a chronic disability).

   b. Check "yes" if the individual has a mental disorder that has resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, and pace; and adaptation to change.

   c. Check "yes" if the individual's treatment history indicates that he or she has experienced (1) psychiatric treatment more intensive than outpatient care more than once in the past 2 years or (2) within the last 2 years, an episode of significant disruption to the normal living situation due to the mental disorder.

3. **Determination of Mental Retardation (MR):** Check "yes" if the individual has a level of retardation (mild, moderate, severe, or profound) described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983) that was manifested before age 18.

4. **Determination of Related Conditions:** Check "yes" only if each item in 4 a-d below is checked. If "no" is checked, do not refer for Level II PAS for related conditions.

   a. Check "yes" if the condition is attributable to any other condition (e.g., cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment or services similar to those for these persons.
   b. Check "yes" if the condition has manifested before age 22.
   c. Check "yes" if the condition is likely to continue indefinitely.
   d. Check "yes" if the condition has resulted in substantial limitations in 3 or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. Circle the applicable areas.

5. **RECOMMENDATION** (Either 5a or b **MUST** be checked.)

   a. Check this category if Question 2 is checked "yes" AND/OR either Question 3 or 4 is checked "yes". Indicate whether referral is for MI or MR, the date the package is referred to the CSB, and where and to whom the package is sent. An individual for whom 5a has been checked may NOT be admitted to a NF until the State Mental Health/Mental Retardation Authority has determined that NF placement is appropriate.

   b. Check this "no referral needed" category ONLY if there is documented evidence as follows:
      - Does not meet the applicable criteria for MI or MR or a related condition
      - Has a primary diagnosis of dementia (including Alzheimer's disease). (If there is a diagnosis of MR, this category does not apply).
      - Has a primary diagnosis of dementia (including Alzheimer's disease) AND a secondary diagnosis of MI
      - Has a severe physical illness (e.g., documented evidence of coma, functioning at brain-stem level, or other diagnoses which result in a level of impairment so severe tha the individual could not be expected to benefit from specialized services. If the assessor determines that an illness not listed here is so severe that the individual could not be expected to benefit from specialized services, documentation describing the severe illness must be attached for review).
      - Is terminally ill (note: a physician must have documented that individual's life expectancy is less than 6 months)

NOTE: WHEN A SCREENING HAS NOT BEEN PERFORMED PRIOR TO AN INDIVIDUAL'S ADMISSION TO A NF IN A TIMELY MANNER, FEDERAL FINANCIAL PARTICIPATION (FFP) IS AVAILABLE ONLY FOR SERVICES FURNISHED AFTER THE SCREENING HAS BEEN PERFORMED.

ASSESSOR INFORMATION

SIGNATURE: First name, middle initial, and last name. **TITLE:** Professional title of the assessor.
SCREENING COMMITTEE: Name/locality of screening committee.
DATE: Date screening was completed. **TELEPHONE NUMBER:** Telephone number, including area code, where assessor may be reached.
STREET ADDRESS: Complete street address, including city, state, and zip code, of the assessor for express mail delivery.

(2)

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Refer for Level II Assessment For MI,	PAS MIMR Level II Reimbursement	DE1355

	MR or Dual Diagnosis	Rate Code	

Input Forms AS-I-055 DMAS 101 - MI/MR For CBC

General Information

This form has two parts: DMAS-101A is page one of the MI/MR screening process for Community Based Care (Waivered) Authorizations. Otherwise known as the Level I portion of the MI/MR screening. DMAS-101B is page two of the MI/MR screening process for Community Based Care (Waivered) Authorizations. Otherwise known as the Level II portion of the MI/MR screening.

Subsystem:	Financial
Source/Originator:	Screening Team
Frequency:	On-Demand
Estimated Volume:	427 Per Month
Programs:	Short Assessment or ACRR Inquiry/Update (AST015) Full Assessment - Page 1 Inquiry/Update (AST025)
Proc/Screen ID:	AS-S-015, AS-S-020, AS-S-025, AS-S-030, AS-S-035

DMAS 101 - MI/MR For CBC (AS-I-055)

A. This section is to be completed by the [illegible] services under the Elderly and Disabled waiver.

Name: _____ Date of Birth: _____ Date NHPAS Request Received: _____
Social Security Number: _____ Medicaid Number: _____ Responsible CSB: _____

1. **DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?** ___ Yes ___ No (Check "yes" only if both a and b below are answered "yes")

   a. does the individual meet the program criteria for the Elderly & Disabled Waiver AND is the individual at imminent risk? __ Yes ___ No
   b. Can a safe and appropriate plan of care be developed to meet all medical/nursing/custodial care needs? ___ Yes ___ No

(If "yes", this form must be completed. If "no", do not complete Level I screening and do not refer for assessment of active tx needs. Individuals who do not meet the above criteria cannot be approved for Medicaid funded waiver services).

2. **DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)?** ___ Yes ___ No
(Check "yes" only if answers a, b, and c below are "yes". If "no", do not refer for assessment of active tx needs for MI Diagnosis.)

   a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? ___ Yes ___ No

   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? __ Yes ___ No

   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? ___ Yes ___ No

3. **DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR) WHICH WAS MANIFESTED BEFORE AGE 18?**
___ Yes ___ No

4. **DOES THE INDIVIDUAL HAVE A RELATED CONDITION?** ___ Yes ___ No
(Check "yes" only if each item below is checked "yes". If "no", do not refer for Level II PAS for related condition.)

   a. Is the condition attributable to any other condition (e.g., cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment of services similar to those for these persons? ___ Yes ___ No

   b. Has the condition manifested before age 22? ____ Yes ___ No

   c. Is the condition likely to continue indefinitely? ___ Yes ___ No

   d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity: self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? ___Yes (circle applicable areas) ___ No

5. **RECOMMENDATION** (Either "a" or "b" MUST be checked.)
   a. ____ **Refer for Level II assessment for "":**
      ___ MI (#2 above is checked "yes")
      ___ MR or Related Condition (#3 or #4 is checked "yes")
      ___ Dual diagnosis (MI and MR/Related Condition categories are checked)

(1)

**NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded waiver until the CSB has completed the DMAS-101 B.

   b. ____ **No referral for active treatment needs assessment required because individual:**
      ___ Does not meet the applicable criteria for serious MI or MR or related condition
      ___ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR
      ___ Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI
      ___ Has a severe physical illness (e.g., documented evidence of coma, functioning at brain-stem level, or other conditions which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services)
      ___ Is terminally ill (note: a physician must have documented that individual's life expectancy is 6 months or less.)

_____ _____ _____
Signature Title Screening Committee

_____ _____ _____
Date Telephone Number Street Address

DMAS-101 A (5/98)

(4)

DMAS 101 - MI/MR For CBC (AS-I-055)

Attached is an assessment completed by _____ Preadmission Screening Team to determine the need and appropriateness of community based services under the Elderly and Disabled Waiver (personal care, adult day health care and/or respite care) for _____.
(Individual applying for services)

As part of our assessment process, we have determined that the individual has:
_____ A condition of mental illness which requires assessment for services needed.
_____ A condition of mental retardation which requires assessment for services needed.

Please complete the information below and return it to _____ _____within 72
Name of Screener making referral *Phone number*
hours of the referral date of _____ so that the assessment and authorization process can be completed.

TO BE COMPLETED BY THE COMMUNITY SERVICES BOARD (Attach additional information as needed.)

The _____Community Services Board assessed the needs of the individual
(Name of CSB)
referenced above on _____.
(Date assessment completed)

1. ☐ The individual does have a condition of mental illness or mental retardation and has the following active treatment needs:

_____
_____
_____
_____
_____

a. Active treatment needs will be met by:

_____
_____
_____

b. If active treatment needs are met by a third party, please attach verification from the third party that all active treatment needs are being met. Also, if active treatment needs are being met by the school system, please explain how active treatment needs will be met during summer vacation:_____
_____
_____

2. ☐ The individual does have a condition of mental illness or mental retardation, but could not benefit from services. Please explain. ***(Note: if this block is checked, but there is no explanation, services under the E&D waiver cannot be authorized).***

_____
_____
_____

3. ☐ The person does not have a condition of mental illness or mental retardation and therefore does not need treatment or services from the CSB.

Name of individual who completed assessment: (Please print name)_____

Signature of individual who completed assessment: _____

Phone Number:_____ Date signed: _____

DMAS-101 B (5/98)

Field Definitions

#	Field Name	Data Element Name	Element ID

1	Refer for Level II Assessment For MI, MR or Dual Diagnosis	PAS MIMR Level II Reimbursement Rate Code	DE1355

Input Forms AS-I-060 DMAS 96 - Medicaid Funded LTC Pre-Admission Screening Authorization

General Information

Medicaid Funded LTC Pre-Admission Screening Authorization. This form is used to verify that the services authorized for Nursing Home or Adult Care Residence (ACR) admissions are valid based on the information gathered in the UAI or AIDS Waiver Assessment forms. This form is used to indicate payment for two levels of assessments. They are as follows: 1. Level I Assessment - This level of assessment can be performed by authorized pre-admission screening providers for all potential participants and all Medicaid Authorization codes. 2. Level II Assessment - This level of assessment can only be performed by Community Service Boards (provider class type 56 with a specialty code of 41 or 42) when the Medicaid Authorization Code for a potential participant's assessment is equal to 01 or 09 and the Level II Assessment Determination Code is equal to 1, 2, or 3. The provider must complete the MI/MR Level II Form for the potential participant.

Subsystem:	Financial
Source/Originator:	Screening Team
Frequency:	On-Demand
Estimated Volume:	427 Per Month
Programs:	Short Assessment or ACRR Inquiry/Update (AST015) Full Assessment - Page 1 Inquiry/Update (AST025) AIDS Waiver Inquiry/Update (AST040)
Proc/Screen ID:	AS-S-015, AS-S-020, AS-S-025, AS-S-030, AS-S-035, AS-S-040

DMAS 96 - Medicaid Funded LTC Pre-Admission Screening Authorization (AS-I-060)

Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form* (DMAS-96)

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.

   Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.

   Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

NOTE: Authorization for Nursing Facility or the Elderly or Disabled With Consumer Direction Waiver is interchangeable. Screenings updates are not required for individuals to move between services because the alternate institutional placement is the same. Alzheimer's Assisted Living Waiver's alternate institutional placement is a nursing facility, however, the individual must also have a diagnosis of Alzheimer's or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify.

1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.

2 = **PACE/LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.

3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).

4 = **ELDERLY OR DISABLED WITH CONSUMER DIRECTION WAIVER** authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.

11 = **ALF RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.

12 = **ALF REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.

14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.

15 = **Technology Assisted Waiver** authorize only if the Individual meets the criteria for admission criteria to a NF specialized care level of care and requires a community-based service to prevent institutionalization.

16 = **Alzheimer's Assisted Living Waiver** authorization only if the Individual meets the criteria for admission to a NF and requires a community-based service to prevent NF institutionalization. Authorize only if the individual has a medical diagnosis of Alzheimer's Disease. *If ALF is authorized*, enter, if known, in item 29, the provider number of the ALF that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ALF.

0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

12. 8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

    9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.
13. Targeted Case Management for ALF *If ARC, ARR or ARI is authorized*; you must indicate whether Targeted Case Management for ALF (quarterly visits) is also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.
14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
15. ALF Reassessment: If this is an ALF Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.
16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

    NOTE: Physicians may write progress notes to the length of stay for individuals moving betwe Facility or the EDCD Waiver. The progress no should provided to the local departments of soc Eligibility workers.
17. Level I/ALF Screening Identification Enter the name of the Level I screening
& agency or facility (for example, Hospital, local DSS, local Health, Area Agency
18. on Aging, CSB, State MH/MR facility, CIL) and below it, in the 10 boxes provided, that entity's 10 digit NPI number or 9 digit Medicaid number.

DMAS 96 - Medicaid Funded LTC Pre-Admission Screening Authorization (AS-I-060)

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____

Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care
1 = Nursing Facility Services
2 = PACE/LTCPHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled with Consumer Direction Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver
15 = Technology Assisted Waiver
16 = Alzheimer's Assisted Living Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same. Alzheimer's Assisted Living Waiver's alternate institutional placement is a nursing facility, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify.

ALF provider name: _____

ALF provider number: ☐

Effective date: _____

Limit date: _____

SERVICE AVAILABILITY
1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

NO MEDICAID SERVICES AUTHORIZED
8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF
0 = No 1 = Yes ☐

Assessment Completed
1 = Full Assessment 2 = Short Assessment ☐

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Level I Physician (Authorization Date)	PAS Level I Physician Authorization Date	DE1346
2	Social Security	Person Social Security Number	DE1000
3	Medicaid Number	Person Enrollee ID	DE1004
5	Is Individual Currently Medicaid Eligible	PAS Medicaid Eligibility Code	DE1161
6	Has individual formally applied for Medicaid?	PAS Medicaid Application Code	DE1156
7	Is individual currently auxiliary grant eligible?	PAS Auxiliary Grant Applied Code	DE1159
8	Medicaid Authorization	PAS Medicaid Authorization Code	DE1157
9	Targeted Case Management for ACR	PAS Case Management Code	DE1352
10	Assessment Completed	Assessment Package Code	DE1372
11	Service Availability	PAS Service Availability Code	DE1160
12	Length of Stay (If approved for Nusing Home)	PAS Length of Stay Code	DE1158
13	Level I Provider Number 1	National Provider Identifier	DE4700
14	Level I Provider Number 2	National Provider Identifier	DE4700
15	Level II Assessment Determination	PAS Level II Assessment Determination Code	DE1165
16	Level 2 Screener Provider Number	National Provider Identifier	DE4700
17	Did individual expire after PAS/ACR Screening?	PAS Patient Expired Code	DE1350

Input Forms AS-I-070 DMAS 99 - Community Based Care Recipient Assessment Report

General Information

This form is used to capture data on Recipient Functional Status, Medical/Nursing Information, Support System, RN Supervision, Consistency and Continuity. This form has the same functional criteria as the UAI. It is used for Personal Care, Adult Day Care and Respite Care. Only the first initial and six-month reassessments should be keyed into the system.

Subsystem:	Financial
Source/Originator:	Servicing Provider
Frequency:	On-Demand
Estimated Volume:	427 Per Month
Programs:	DMAS 99 Nursing Assessment Inquiry/Update (AST045)
Proc/Screen ID:	AS-S-045

DMAS 99 - Community Based Care Recipient Assessment Report (AS-I-070)

Community-Based Care Recipient Assessment Report

☐ Initial ☐ Monthly ☐ 6 month Reassessment and/or Desk Review

Recipient Name: (1) _____ Date of Birth: _____

Medicaid ID Number: (2) _____ Start of Care: (3) _____

Recipient's Current Address: _____ Agency Name: _____

_____

_____

_____ Provider ID Number: (4)

Phone: ( ) _____

FUNCTIONAL STATUS (Shaded areas denote independence or mechanical dependence)

ADLS	Needs No Help	MH Only	Human Help Supervise	Human Help Phys. Asst.	MH & Human Help Supervise	MH & Human Help Phys. Asst.	Performed By Others	Is Not Performed
Bathing (5)								
Dressing (6)								
Toileting (7)								
Transferring (8)								
Eating/Feeding (9)								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel (10)							
Bladder (11)							

MOBILITY: (12)

Needs No Help	MH Only	Human Help Supervise	Human Help Phys. Asst.	MH & Human Help Supervise	MH & Human Help Phys. Asst.	Confined Moves About	Confined Does Not Move About

ORIENTATION: (13)

Oriented	Disoriented-Some Spheres/Some Time	Disoriented-Some Spheres/All Time	Disoriented-All Spheres/Some Time	Disoriented-All Spheres/All Time	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR: (14)

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior: Source of Info:

JOINT MOTION: (15) MED. ADMINISTRATION: (16)

MEDICAL/NURSING INFORMATION

Diagnoses _____

_____

Current Health Status/Condition: _____

_____

_____

Current Medical Nursing Needs: _____

_____

DMAS 99 - Community Based Care Recipient Assessment Report (AS-I-070)

Therapies/Special Medical Procedures: _____

Hospitalizations: Date(s): _____ Reason(s): _____

SUPPORT SYSTEM

Hours Aide Provides Care to Recipient: Total Weekly Hours: (17) Days per Week: (18)
Other Medicaid/Non-Medicaid Funded Services Received: _____

Family/Other Support: _____

Who other than the recipient is to sign the aide logs? _____
Is Recipient in need of supervision at all times to be maintained safely?: ☐ Yes ☐ No

RN SUPERVISION

Dates of RN supervisory visits for the last 6 months: _____

Does the Aide document accurately the care provided? ☐ Yes ☐ No
Does the care plan reflect the needs of the Recipient? ☐ Yes ☐ No
If No to either, please describe follow-up: _____

CONSISTENCY AND CONTINUITY

Number of Days of No Service In the Last 6 Months: (Do Not include Hospitalizations) _____

Number of Aides Assigned to Case in the Last 6 Months: Regular Aides : _____ Sub-Aides: _____
Has the recipient or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If Yes, please describe problem(s) and the follow-up taken: _____

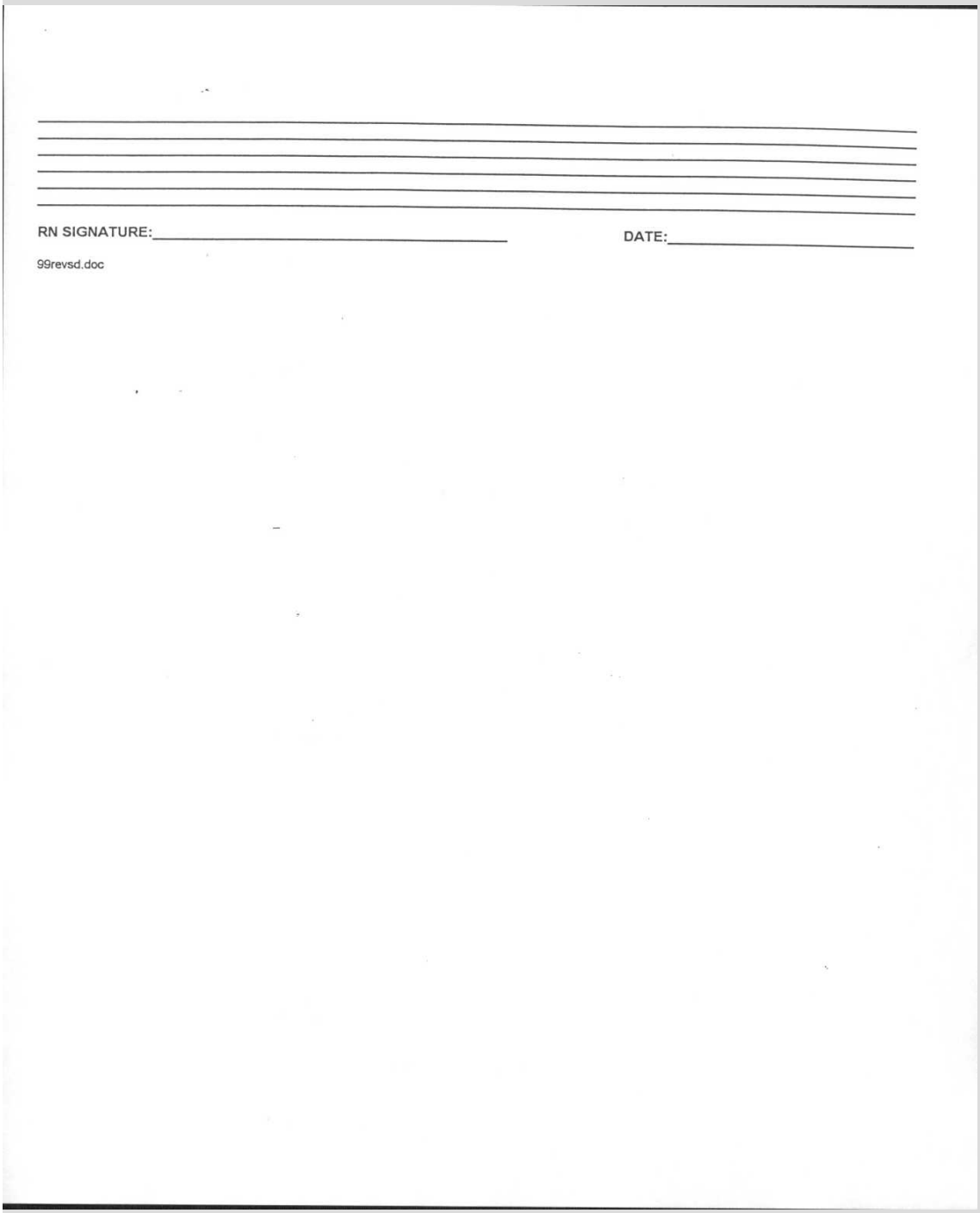
Date of most recent DMAS 122: _____ Patient Pay Amount:: _____

RN Supervisor/Coordinator Signature: _____ Date: _____

Aide Present? ☐ Yes ☐ No Name of Aide: _____ Regular Aide ☐ / Sub Aide ☐

NURSING NOTES: (Rns may utilize space below for documentation of pertinent issues that may occur between home visits)

DMAS 99 - Community Based Care Recipient Assessment Report (AS-I-070)



RN SIGNATURE:_____ DATE:_____

99revsd.doc

Field Definitions

#	Field Name	Data Element Name	Element ID

1	Recipient Name	Person Name	DE1001
2	Medicaid ID Number	Person Enrollee ID	DE1004
3	Start of Care	Assessment Date	DE1023
4	Provider ID Number	National Provider Identifier	DE4700
5	Bathing	CBC Functional Status - Bathing Code	DE1377
6	Dressing	CBC Functional Status - Dressing Code	DE1379
7	Toileting	CBC Functional Status - Toileting Code	DE1381
8	Transferring	CBC Functional Status - Transferring Code	DE1382
9	Eating/Feeding	CBC Functional Status - Eating / Feeding Code	DE1380
10	Bowel	CBC Functional Status - Bowel Code	DE1386
11	Bladder	CBC Functional Status - Bladder Code	DE1378
12	Mobility	CBC Functional Status - Mobility Code	DE1375
13	Orientation	CBC Cognitive Function - Orientation Code	DE1373
14	Behavior	CBC Behavior Pattern Code	DE1374
15	Joint Motion	CBC Function Status - Joint Motion Code	DE1383
16	Med. Administration	CBC Administer Medication Code	DE1376
17	Total Weekly Hours	CBC Nursing Information - Aide Weekly Hours	DE1358
18	Days per Week	CBC Nursing Information - Aide Days per Week	DE1359

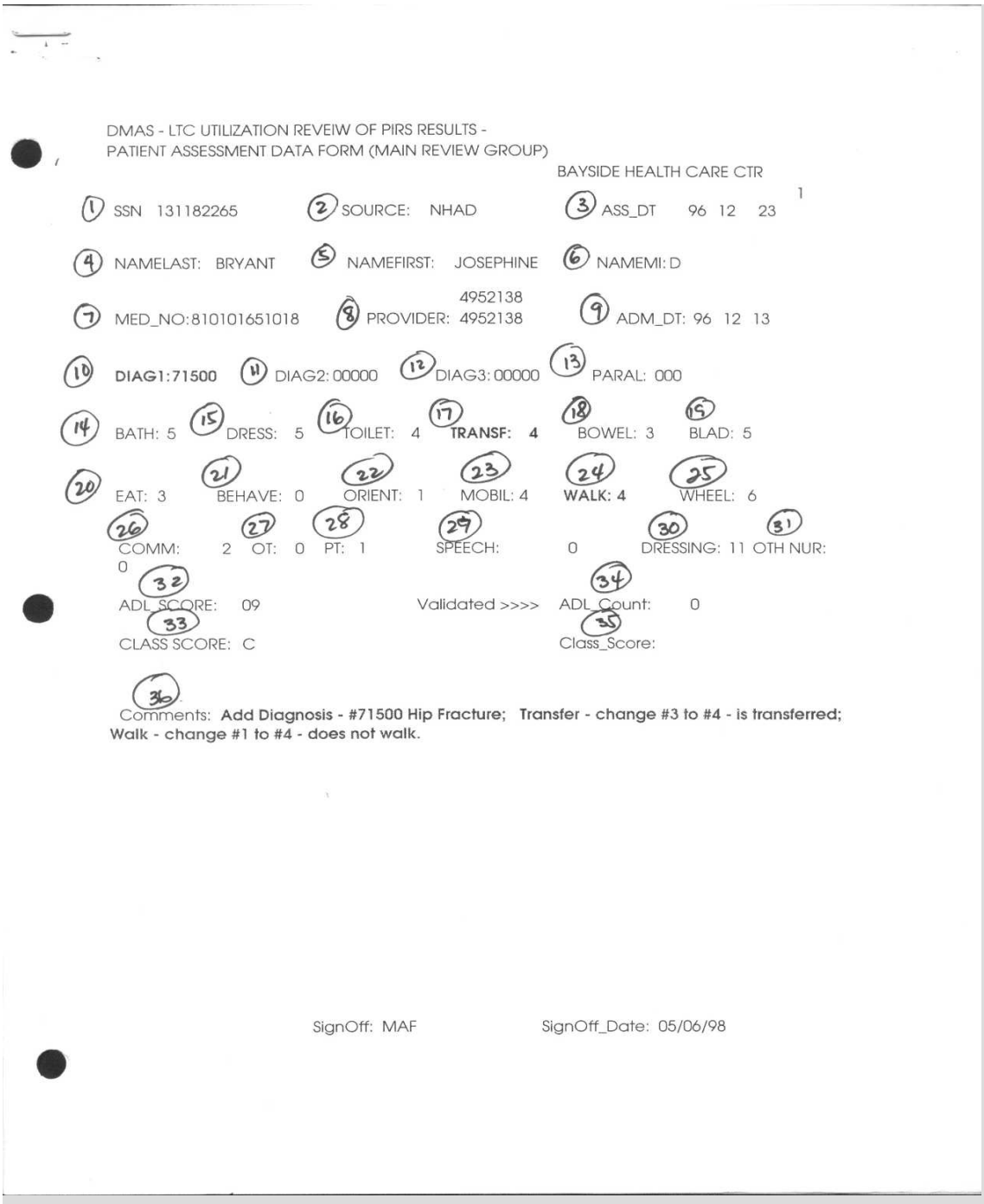
Input Forms AS-I-080 PIRS TADS E-Mail - DMAS LTC Utilization Review of PIRS Results

General Information

DMAS - LTC Utilization Review of PIRS Results - Patient Assessment Data Form (Main Review Group). This is a free-form document sent from DMAS via e-mail and is currently referred to as TADS. It is primarily used to inform FHSC of assessments that require information to be updated on the online screens. Only changes to be made are those that have been written in the comments section.

Subsystem:	Financial
Source/Originator:	DMAS
Frequency:	Weekly
Estimated Volume:	N/A
Programs:	Level of Care Inquiry/Update (AST075)
Proc/Screen ID:	AS-S-010, AS-S-075

PIRS TADS E-Mail - DMAS LTC Utilization Review of PIRS Results (AS-I-080)



DMAS - LTC UTILIZATION REVEIW OF PIRS RESULTS -
PATIENT ASSESSMENT DATA FORM (MAIN REVIEW GROUP)

BAYSIDE HEALTH CARE CTR

1 SSN 131182265 2 SOURCE: NHAD 3 ASS_DT 96 12 23

4 NAMELAST: BRYANT 5 NAMEFIRST: JOSEPHINE 6 NAMEMI: D

7 MED_NO:810101651018 8 PROVIDER: 4952138 4952138 9 ADM_DT: 96 12 13

10 DIAG1:71500 11 DIAG2: 00000 12 DIAG3: 00000 13 PARAL: 000

14 BATH: 5 15 DRESS: 5 16 TOILET: 4 17 TRANSF: 4 18 BOWEL: 3 19 BLAD: 5

20 EAT: 3 21 BEHAVE: 0 22 ORIENT: 1 23 MOBIL: 4 24 WALK: 4 25 WHEEL: 6

26 COMM: 2 27 OT: 0 28 PT: 1 29 SPEECH: 0 30 DRESSING: 11 31 OTH NUR: 0

32 ADL_SCORE: 09 Validated >>>> 34 ADL_Count: 0

33 CLASS SCORE: C 35 Class_Score:

36 Comments: **Add Diagnosis - #71500 Hip Fracture; Transfer - change #3 to #4 - is transferred; Walk - change #1 to #4 - does not walk.**

SignOff: MAF SignOff_Date: 05/06/98

Field Definitions

#	Field Name	Data Element Name	Element ID
1	SSN	Person Social Security Number	DE1000
2	SOURCE	Assessment Source Code	DE1022
3	ASS_DT	Assessment Date	DE1023

4	NAMELAST	Person Last Name	DE1336
5	NAMEFIRST	Person First Name	DE1334
6	NAMEMI	Person Middle Initial	DE1335
7	MED_NO	Person Enrollee ID	DE1004
8	PROVIDER	National Provider Identifier	DE4700
9	ADM_DT	PIRS Patient's Admission Date	DE1042
10	DIAG1	PIRS Medical Diagnosis Code	DE1055
11	DIAG2	PIRS Medical Diagnosis Code	DE1055
12	DIAG3	PIRS Medical Diagnosis Code	DE1055
13	PARAL	PIRS Medical Status - Paralysis/Paresis Code	DE1054
14	BATH	PIRS Function Status - Bath Code	DE1080
15	DRESS	PIRS Function Status - Dressing Code	DE1081
16	TOILET	PIRS Function Status - Toilet Code	DE1082
17	TRANSF	PIRS Function Status - Transfer Code	DE1083
18	BOWEL	PIRS Function Status - Bowel Code	DE1084
19	BLAD	PIRS Function Status - Bladder Code	DE1085
20	EAT	PIRS Function Status - Eating/Feeding Code	DE1086
21	BEHAVE	PIRS Function Status - Behavior Code	DE1087
22	ORIENT	PIRS Function Status - Orientation Code	DE1088
23	MOBIL	PIRS Function Status - Mobility Level Code	DE1089
24	WA	PIRS Function Status - Walking Code	DE1090
25	WHEEL	PIRS Function Status - Wheeling Code	DE1091
26	COMM	PIRS Function Status - Communications Code	DE1093
27	OT	PIRS Current Service - Occupational Therapy Code	DE1101
28	PT	PIRS Current Service - Physical Therapy Code	DE1102
29	SPEECH	PIRS Current Service - Speech Therapy Code	DE1103
30	DRESSING	PIRS Current Service - Daily Dress-	DE1116

		ing Code	
31	OTH NUR	PIRS Current Service - Physical Ther-apy Code	DE1102
32	ADL SCORE		DE0000
33	CLASS SCORE		DE0000
34	VALIDATED ADL COUNT		DE0000
35	VALIDATED CLASS_SCORE		DE0000
36	COMMENTS		DE0000

Input Forms AS-I-090 Virginia Uniform Assessment Instrument

General Information

The assessment form is used for Elderly and Disabled Waiver, Nursing Facility, or Assisted Living Services. The data from this paper form are entered into the Assessment Maintenance Application. The UAI contains two components: 1. Short Assessment - contains identification/background questions and functional status. 2. Full Assessment - contains Short Assessment, health, psycho-social, and caregiver assessments, and assessment summary.

Subsystem:	Financial
Source/Originator:	Screening Team
Frequency:	On-Demand
Estimated Volume:	427 Per Month
Programs:	Short Assessment or ACRR Inquiry/Update (AST015) Full Assessment - Page 1 Inquiry/Update (AST025) AIDS Waiver Inquiry/Update (AST040)
Proc/Screen ID:	AS-S-015, AS-S-020, AS-S-025, AS-S-030, AS-S-035, AS-S-040

Virginia Uniform Assessment Instrument (AS-I-090)

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen: (1) ___/___/___
Assessment: (1.1) ___/___/___
Reassessment: (1.2) ___/___/___

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: (2) _____ (Last) _____ (First) _____ (Middle Initial) Client SSN: (3) ___ - ___ - ____

Address: (4) _____ (Street) _____ (City) (5) _____ (State) _____ (Zip Code)

Phone: ( ) _____ City/County Code: (6) _____ _____ _____

Directions to House: Pets?

Demographics

Birthdate: (7) ___/___/___ (Month) (Day) (Year) Age: _____ Sex: (8) ___ Male 0 ___ Female 1

Marital Status: (9) ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

Race: (10)
___ White 0
___ Black/African American 1
___ American Indian 2
___ Oriental/Asian 3
___ Alaskan Native 4
___ Unknown 9 _____
Ethnic Origin: _____

Education:
___ Less than High School 0
___ Some High School 1
___ High School Graduate 2
___ Some College 3
___ College Graduate 4
___ Unknown 9
Specify: _____

Communication of Needs: (11)
___ Verbally, English 0
___ Verbally, Other Language 1
Specify: _____
___ Sign Language/Gestures/Device 2
___ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ Relationship: _____

Address: _____ Phone: (H) _____ (W) _____

Name: _____ Relationship: _____

Address: _____ Phone: (H) _____ (W) _____

Name of Primary Physician: _____ Phone: _____

Address: _____

Initial Contact

Who called: _____ (Name) _____ (Relation to Client) _____ (Phone)

Presenting Problem/Diagnosis:

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	Check All Services That Apply	Provider/Frequency:
___	___	Adult Day Care (81)	
___	___	Adult Protective (82)	
___	___	Case Management (83)	
___	___	Chore/Companion/Homemaker (84)	
___	___	Congregate Meals/Senior Center (85)	
___	___	Financial Management/Counseling (86)	
___	___	Friendly Visitor/Telephone Reassurance (87)	
___	___	Habilitation/Supported Employment (88)	
___	___	Home Delivered Meals (89)	
___	___	Home Health/Rehabilitation (90)	
___	___	Home Repairs/Weatherization (91)	
___	___	Housing (92)	
___	___	Legal (93)	
___	___	Mental Health (Inpatient/Outpatient) (94)	
___	___	Mental Retardation (95)	
___	___	Personal Care (96)	
___	___	Respite (97)	
___	___	Substance Abuse (98)	
___	___	Transportation (99)	
___	___	Vocational Rehab/Job Counseling (100)	
___	___	Other: (101)	

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit: _____

Optional: Total monthly family income: _____

Do you currently receive income from . . . ?

No 0	Yes 1	Optional: Amount	
___	___	Black Lung,	
___	___	Pension,	
___	___	Social Security,	
___	___	SSI/SSDI,	
___	___	VA Benefits,	(113)
___	___	Wages/Salary,	(115)
___	___	Other,	

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		Names
___	___	Legal Guardian,	(102)
___	___	Power of Attorney,	(103)
___	___	Representative Payee,	(104)
___	___	Other,	(105)

Do you receive any benefits or entitlements?

No 0	Yes 1		
___	___	Auxiliary Grant	(106)
___	___	Food Stamps	(107)
___	___	Fuel Assistance	(108)
___	___	General Relief	(109)
___	___	State and Local Hospitalization	(110)
___	___	Subsidized Housing	(111)
___	___	Tax Relief	(112)

What types of health insurance do you have?

No 0	Yes 1		
___	___	Medicare, #	(114)
___	___	Medicaid, #	
(116)		*Pending:* ☐ No 0 ☐ Yes 1	
(117)		*QMB/SLMB:* ☐ No 0 ☐ Yes 1	
___	___	All Other Public/Private:	

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

Physical Environment

(12) **Where do you usually live? Does anyone live with you?**

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House: Own 0				
___ House: Rent 1				
___ House: Other 2				
___ Apartment 3				
___ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50			
___ Adult Foster 60			
___ Nursing Facility 70	–		
___ Mental Health/ Retardation Facility 80			
___ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
___	___	Barriers to Access
___	___	Electrical Hazards
___	___	Fire Hazards/No Smoke Alarm
___	___	Insufficient Heat/Air Conditioning
___	___	Insufficient Hot Water/Water
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)
___	___	Lack of/Defective Stove, Refrigerator, Freezer
___	___	Lack of/Defective Washer/Dryer
___	___	Lack of/Poor Bathing Facilities
___	___	Structural Problems
___	___	Telephone Not Accessible
___	___	Unsafe Neighborhood
___	___	Unsafe/Poor Lighting
___	___	Unsanitary Conditions
___	___	Other: _____

Describe Problems:

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing (13)											
Dressing (14)											
Toileting (15)											
Transferring (16)											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding (17)											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel (18)								
Bladder (19)								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking (20)									
Wheeling (21)									
Stairclimbing (22)									
								Confined Moves About	Confined Does Not Move About
Mobility (23)									

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation (24)		
Housekeeping (25)		
Laundry (26)		
Money Management (27)		
Transportation (28)		
Shopping (29)		
Using Phone (30)		
Home Maintenance (31)		

Comments:

Outcome: Is this a short assessment?

___ No, Continue with Section ➔ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____ Agency: _____

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital (119)			
		Nursing Facility (120)			
		Adult Care Residence (121)			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0	Yes 1		Location
___	___	Living Will, (122)	
___	___	Durable Power of Attorney for Health Care, (123)	
___	___	Other, (124)	

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses — Date of Onset

Enter Codes for 3 Major, Active Diagnoses: ___ None 00 ___ (32) DX1 ___ (33) DX2 ___ (34) DX3

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
0.		

Total No. of Medications: (35) (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: ___

Do you have any problems with medicine(s) . . . ?

No 0 Yes 1

___ ___ Adverse reactions/allergies
___ ___ Cost of medication
___ ___ Getting to the pharmacy
___ ___ Taking them as instructed/prescribed
___ ___ Understanding directions/schedule

How do you take your medicine(s)? (36)

___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

Describe help: ___
Name of helper: ___

Diagnoses:

- **Alcoholism/Substance Abuse** (01)
- **Blood-Related Problems** (02)
- **Cancer** (03)
- **Cardiovascular Problems**
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- **Dementia**
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- **Developmental Disabilities**
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich's Ataxia (14)
    - Multiple Sclerosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- **Digestive/Liver/Gall Bladder** (18)
- **Endocrine (Gland) Problems**
  - Diabetes (19)
  - Other Endocrine Problems (20)
- **Eye Disorders** (21)
- **Immune System Disorders** (22)
- **Muscular/Skeletal**
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- **Neurological Problems**
  - Brain Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- **Psychiatric Problems**
  - Anxiety Disorders (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- **Respiratory Problems**
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- **Urinary/Reproductive Problems**
  - Renal Failure (40)
  - Other Urinary/Reproductive Problems (41)
- **All Other Problems** (42)

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision (37)					
Hearing (38)					
Speech (39)					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs? (40)

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations (41)	Missing Limbs (42)	Paralysis/Paresis (43)
___ None 000	___ None 000	___ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: _____
___ Combination 4	___ Combination 4	_____
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: (44) _____ (inches) Weight: (45) _____ (lbs.) Recent Weight Gain/Loss: (46) ___ No 0 ___ Yes 1
Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
___	___	Food Allergies
___	___	Inadequate Food/Fluid Intake
___	___	Nausea/Vomiting/Diarrhea
___	___	Problems Eating Certain Foods
___	___	Problems Following Special Diets
___	___	Problems Swallowing
___	___	Taste Problems
___	___	Tooth or Mouth Problems
___	___	Other: _____

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?

No 0	Yes 1		Frequency
___	___	Occupational (47)	
___	___	Physical (48)	
___	___	Reality/Remotivation (49)	
___	___	Respiratory (50)	
___	___	Speech (51)	
___	___	Other (52)	

Do you have any pressure ulcers? (53)

		Location/Size
___	None 0	
___	Stage I 1	
___	Stage II 2	
___	Stage III 3	
___	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as . . . ?

No 0	Yes 1		Site, Type, Frequency
___	___	Bowel/Bladder Training (54)	
___	___	Dialysis (55)	
___	___	Dressing/Wound Care (56)	
___	___	Eyecare (57)	
___	___	Glucose/Blood Sugar (58)	
___	___	Injections/IV Therapy (59)	
___	___	Oxygen (60)	
___	___	Radiation/Chemotherapy (61)	
___	___	Restraints (Physical/Chemical) (62)	
___	___	ROM Exercise (63)	
___	___	Trach Care/Suctioning (64)	
___	___	Ventilator (65)	
___	___	Other: (66)	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? (67) ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

(68) **Orientation** *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).

Place: **Where are we now** *(state, county, town, street/route number, street name/box number)*?
Give the client 1 point for each correct response.

Time: **Would you tell me the date today** *(year, season, date, day, month)*?

___ Oriented 0
___ Disoriented - Some spheres, some of the time 1
___ Disoriented - Some spheres, all the time 2
___ Disoriented - All spheres, some of the time 3
___ Disoriented - All spheres, all of the time 4
___ Comatose 5

Spheres affected: _____

Recall/Memory/Judgement

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)?

Judgement: **If you needed help at night, what would you do?**

No 0 Yes 1
___ ___ Short -Term Memory Loss? (125)
___ ___ Long-Term Memory Loss? (126)
___ ___ Judgement Problem? (127)

Optional: **MMSE Score**

_____ (5)
_____ (5)
_____ (3)
_____ (5)

Total: (128) _____

Note: Score of 14 or below implies cognitive impairment

Behavior Pattern

(69) **Does the client ever wander without purpose** (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

___ Appropriate 0
___ Wandering/Passive - Less than weekly 1
___ Wandering/Passive - Weekly or more 2
___ Abusive/Aggressive/Disruptive - Less than weekly 3
___ Abusive/Aggressive/Disruptive - Weekly or more 4
___ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
___	___	Change in work/employment	___	___	Financial problems	___	___	Victim of a crime
___	___	Death of someone close	___	___	Major illness - family/friend	___	___	Failing health
___	___	Family conflict	___	___	Recent move/relocation	___	___	Other: _____

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

___ ___ Solitary Activities, _____

___ ___ With Friends/Family, _____

___ ___ With Groups/Clubs, _____

___ ___ Religious Activities, _____

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children	Other Family	Friends/Neighbors
___ No Children 0	___ No Other Family 0	___ No Friends/Neighbors 0
___ Daily 1	___ Daily 1	___ Daily 1
___ Weekly 2	___ Weekly 2	___ Weekly 2
___ Monthly 3	___ Monthly 3	___ Monthly 3
___ Less than Monthly 4	___ Less than Monthly 4	___ Less than Monthly 4
___ Never 5	___ Never 5	___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ No 0 ___ Yes 1

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1 (129)

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

___ No 0 ___ Yes 1
Describe concerns: _____

Do (did) you ever use alcohol/other mood-altering substances with...

No 0 Yes 1
___ ___ Prescription drugs?
___ ___ OTC medicine?
___ ___ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you...

No 0 Yes 1
___ ___ Sleep?
___ ___ Relax?
___ ___ Get more energy?
___ ___ Relieve worries?
___ ___ Relieve physical pain?

Describe what and how often:

Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

Virginia Uniform Assessment Instrument (AS-I-090)

CLIENT NAME: Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.

Caregiver Assessment

Does the client have an informal caregiver? (70)

___ No 0 (Skip to Section on Preferences) ___ Yes 1

Where does the caregiver live? (130)

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . . (71)

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver? (131)

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

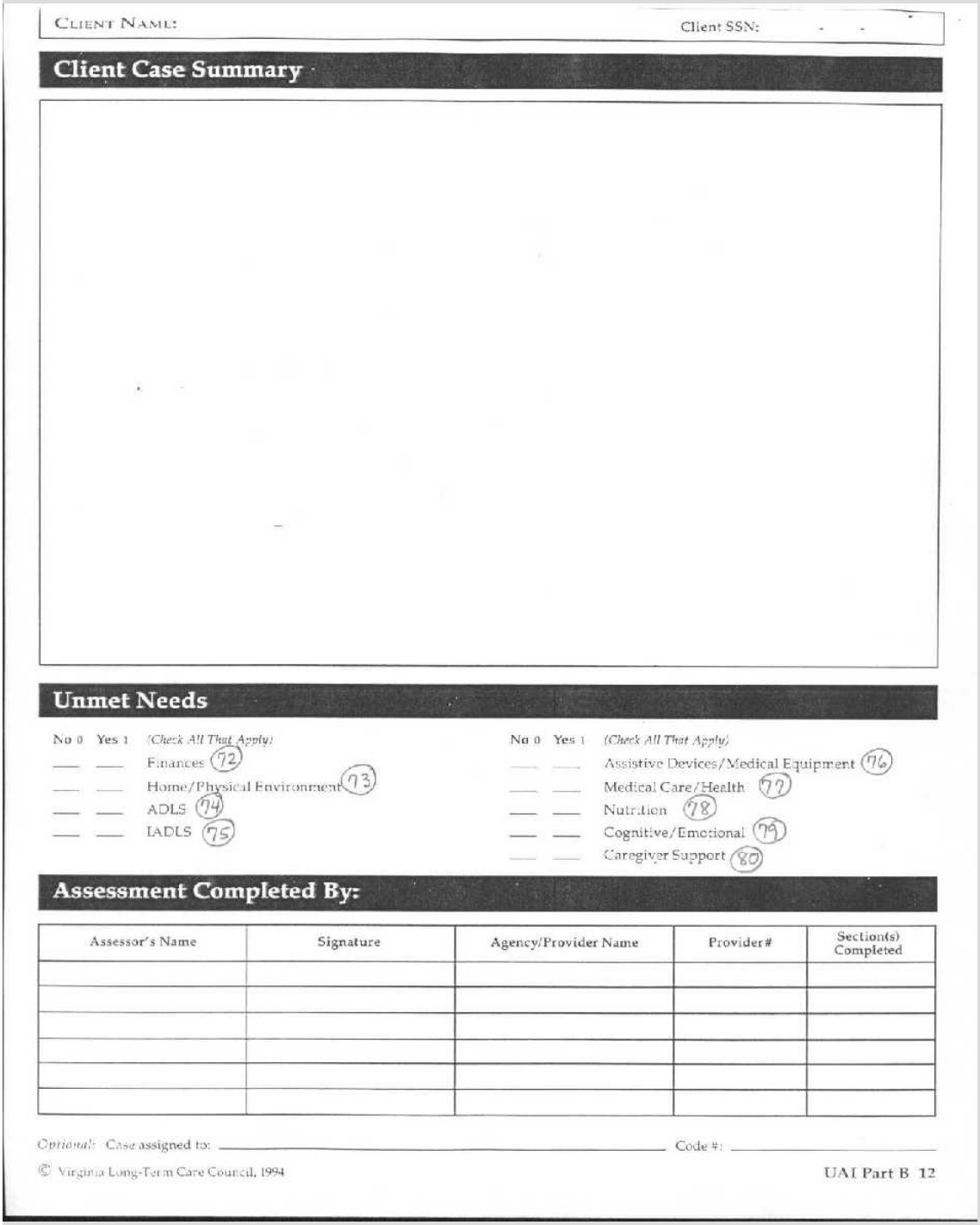
Preferences

Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

Virginia Uniform Assessment Instrument (AS-I-090)



CLIENT NAME: Client SSN: - -

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)	No 0	Yes 1	(Check All That Apply)
___	___	Finances (72)	___	___	Assistive Devices/Medical Equipment (76)
___	___	Home/Physical Environment (73)	___	___	Medical Care/Health (77)
___	___	ADLS (74)	___	___	Nutrition (78)
___	___	IADLS (75)	___	___	Cognitive/Emotional (79)
			___	___	Caregiver Support (80)

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

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Field Definitions

#	Field Name	Data Element Name	Element ID

1	Dates: Screen	Assessment Date	DE1023
1	Dates: Assessment	Assessment Date	DE1023
1	Dates: Reassessment	Assessment Date	DE1023
2	Client Name	Person Name	DE1001
3	Client SSN	Person Social Security Number	DE1000
4	Address	Person Address	DE1002
5	City	Person Address	DE1002
6	City/County Code	Assessment City / County Code	DE1019
7	Birthdate	Person Birth Date	DE1006
8	Sex	Person Gender Code	DE1010
9	Marital Status	Person Marital Status Code	DE1011
10	Race	Person Race Code	DE1012
11	Communication Needs	UAI Communication of Needs Code	DE1211
12	Where do you usually live?	UAI Usually Live Physical Environment Code	DE1212
13	ADLS: Bathing	UAI Functional Status - Bathing Code	DE1213
14	ADLS: Dressing	UAI Functional Status - Dressing Code	DE1214
15	ADLS: Toileting	UAI Functional Status - Toileting Code	DE1215
16	ADLS: Transferring	UAI Functional Status - Transferring Code	DE1216
17	ADLS: Eating/Feeding	UAI Functional Status - Eating / Feeding Code	DE1217
18	Continence: Bowel	UAI Functional Status - Bowel Code	DE1218
19	Continence: Bladder	UAI Functional Status - Bladder Code	DE1219
20	Ambulation: Walking	UAI Functional Status - Walking Code	DE1220
21	Ambulation: Wheeling	UAI Functional Status - Wheeling Code	DE1221
22	Ambulation: Stairclimbing	UAI Functional Status - Stair Climbing Code	DE1222
23	Ambulation: Mobility	UAI Functional Status - Mobility Code	DE1223
24	IADLS: Meal Preparation	UAI Functional Status - Meal Preparation Code	DE1224
25	IADLS: Housekeeping	UAI Functional Status - Housekeeping Code	DE1225
26	IADLS: Laundry	UAI Functional Status - Laundry	DE1226

		Code	
27	IADLS: Money Management	UAI Functional Status - Money Management Code	DE1227
28	IADLS: Transportation	UAI Functional Status - Transportation Code	DE1228
29	IADLS: Shopping	UAI Functional Status - Shopping Code	DE1229
30	IADLS: Using Phone	UAI Functional Status - Using Phone Code	DE1230
31	IADLS: Home Maintenance	UAI Functional Status - Home Maintenance Code	DE1231
32	Active Diagnosis: DX1	UAI Medication Profile - Medical Diagnosis Code	DE1232
33	Active Diagnosis: DX2	UAI Medication Profile - Medical Diagnosis Code	DE1232
34	Active Diagnosis: DX3	UAI Medication Profile - Medical Diagnosis Code	DE1232
35	Total No. of Medications	UAI Medication Profile - Number Of Medications	DE1233
36	How do you take your medicine(s)	UAI Medication Profile - Administer Medication Code	DE1234
37	Sensory Functions: Vision	UAI Sensory Function - Vision Code	DE1235
38	Sensory Functions: Hearing	UAI Sensory Function - Hearing Code	DE1236
39	Sensory Functions: Speech	UAI Sensory Function - Speech Code	DE1237
40	Physical Status: Joint Motion	UAI Sensory Function - Joint Motion Code	DE1238
41	Physical Status: Fractures Dislocations	UAI Sensory Function - Fractures / Dislocations Code	DE1239
42	Physical Status: Missing Limbs	UAI Sensory Function - Missing Limbs Code	DE1240
43	Physical Status: Paralysis / Paresis	UAI Sensory Function - Paralysis / Paresis Code	DE1241
44	Nutrition: Height	Assessment Patient's Height	DE1242
45	Nutrition: Weight	Assessment Patient's Weight	DE1243
46	Nutrition: Recent Weight Gain / Loss	Assessment Patient's Recent Weight Gain Or Loss Code	DE1244
47	Occupational	UAI Current Medical Services - Occupational Therapy Code	DE1245
48	Physical	UAI Current Medical Services - Physical Therapy Code	DE1246

49	Reality / Remotivation	UAI Current Medical Services - Reality / Remotivation Therapy Code	DE1247
50	Respiratory	UAI Current Medical Services - Respiratory Therapy Code	DE1248
51	Speech	UAI Current Medical Services - Speech Therapy Code	DE1249
52	Other	UAI Current Medical Services - Other Therapies Code	DE1250
53	Do you have any pressure ulcers?	UAI Current Medical Services - Pressure Ulcers Code	DE1251
54	Bowel/Bladder Training Dialysis	UAI Current Medical Services - Bowel / Bladder Training Code	DE1252
55	Dialysis	UAI Current Medical Services - Dialysis Code	DE1253
56	Dressing/Wound Care	UAI Current Medical Services - Dressing Wound Care Code	DE1254
57	Eyecare	UAI Current Medical Services - Eye Care Code	DE1255
58	Glucose/Blood Sugar	UAI Current Medical Services - Glucose / Blood Sugar Code	DE1256
59	Injections/IV Therapy	UAI Current Medical Services - Injections / IV Therapy Code	DE1257
60	Oxygen	UAI Current Medical Services - Oxygen Code	DE1258
61	Radiation/Chemotherapy	UAI Current Medical Services - Radiation / Chemotherapy Code	DE1259
62	Restraints (Physical/Chemical)	UAI Current Medical Services - Restraints Code	DE1260
63	ROM Exercise	UAI Current Medical Services - Range Of Motion Exercise Code	DE1261
64	Trach Care/Suctioning	UAI Current Medical Services - Trach Care / Suctioning Code	DE1262
65	Ventilator	UAI Current Medical Services - Ventilator Code	DE1263
66	Other	UAI Current Medical Services - Other Special Procedures Code	DE1264
67	Are there ongoing medical/nursing needs?	UAI Ongoing Medical Nursing Needs Code	DE1265
68	Orientation	UAI Cognitive Function - Orientation Code	DE1266
69	Behavior Pattern	UAI Behavior Pattern Code	DE1267
70	Does the client have an informal care-	UAI Informal Caregiver Code	DE1268

	giver		
71	Is the caregiver's help	UAI Informal Caregiver Help Code	DE1269
72	Unmet Needs: Finances	UAI Unmet Needs - Finances Code	DE1271
73	Unmet Needs: Home/Physical Environment	UAI Unmet Needs - Home / Physical Environment Code	DE1270
74	Unmet Needs: ADLS	UAI Unmet Needs - Activities of Daily Living Code	DE1272
75	Unmet Needs: IADLS	UAI Unmet Needs - Instrumental Activities of Daily Living Code	DE1273
76	Unmet Needs: Assistive Devices/Medical Equipment	UAI Unmet Needs - Assistive Devices / Medical Equipment Code	DE1274
77	Unmet Needs: Medical Care/Health	UAI Unmet Needs - Medical Care / Health Code	DE1275
78	Unmet Needs: Nutrition	UAI Unmet Needs - Nutrition Code	DE1276
79	Unmet Needs: Cognitive/Emotional	UAI Unmet Needs - Cognitive / Emotional Code	DE1277
80	Unmet Needs: Caregiver Support	UAI Unmet Needs - Caregiver Support Code	DE1278
81	Adult Day Care	UAI Current Formal Service - Adult Day Care Code	DE1280
82	Adult Protective	UAI Current Formal Service - Adult Protective Code	DE1281
83	Case Management	UAI Current Formal Service - Case Management Code	DE1282
84	Chore/Companion/Homemaker	UAI Current Formal Service - Chore, Companion, Homemaker Code	DE1283
85	Congregate Meals/Senior Center	UAI Current Formal Service - Congregate Meals, Senior Center Code	DE1284
86	Financial Management/Counseling	UAI Current Formal Service - Financial Management, Counseling Code	DE1285
87	Friendly Visitor/Telephone Reassurance	UAI Current Formal Service - Friendly Visitor, Telephone Reassurance Code	DE1286
88	Habilitation/Supported Employment	UAI Current Formal Service - Habilitation, Supported Employment Code	DE1287
89	Home Delivered Meals	UAI Current Formal Service - Home Delivered Meals Code	DE1288
90	Home Health/Rehabilitation	UAI Current Formal Service - Home Health, Rehabilitation Code	DE1289
91	Home Repairs/Weatherization	UAI Current Formal Service - Home Repairs, Weatherization Code	DE1290

92	Housing	UAI Current Formal Service - Housing Code	DE1291
93	Legal	UAI Current Formal Service - Legal Code	DE1292
94	Mental Health (Inpatient/Outpatient)	UAI Current Formal Service - Mental Health (Inpatient, Outpatient) Code	DE1293
95	Mental Retardation	UAI Current Formal Service - Mental Retardation Code	DE1294
96	Personal Care	UAI Current Formal Service - Personal Care Code	DE1295
97	Respite	UAI Current Formal Service - Respite Code	DE1296
98	Substance Abuse	UAI Current Formal Service - Substance Abuse Code	DE1297
99	Transportation	UAI Current Formal Service - Transportation Code	DE1298
100	Vocational Rehab/Job Counseling	UAI Current Formal Service - Vocational Rehab , Job Counseling Code	DE1299
101	Other	UAI Current Formal Service - Other Code	DE1300
102	Legal Guardian	UAI Financial Resources - Legal Guardian Representative Code	DE1301
103	Power of Attorney	UAI Financial Resources - Power of Attorney Representative Code	DE1302
104	Representative Payee	UAI Financial Resources - Payee Representative Code	DE1303
105	Other	UAI Financial Resources - Other Representative Code	DE1304
106	Auxiliary Grant	UAI Financial Resources - Auxiliary Grant Benefits Code	DE1305
107	Food Stamps	UAI Financial Resources - Food Stamps Benefits Code	DE1306
108	Fuel Assistance	UAI Financial Resources - Fuel Assistance Benefits Code	DE1307
109	General Relief	UAI Financial Resources - General Relief Benefits Code	DE1308
110	State and Local Hospitalization	UAI Financial Resources - State and Local Hospitalization Benefits Code	DE1309
111	Subsidized Housing	UAI Financial Resources - Subsidized Housing Benefits Code	DE1310
112	Tax Relief	UAI Financial Resources - Tax Relief Benefits Code	DE1311

113	Medicare (Insurance)	UAI Financial Resources - Medicare Insurance Code	DE1312
114	Medicare #	Person Medicare Number	DE1005
115	Medicaid (Insurance)	UAI Financial Resources - Medicaid Insurance Code	DE1313
116	Medicaid Pending	UAI Financial Resources - Medicaid Pending Insurance Code	DE1315
117	Medicaid QMB/SLMB	UAI Financial Resources - Medicaid QMB, SLMB Insurance Code	DE1316
118	All Other Public/Private	UAI Financial Resources - Other Public, Private Insurance Code	DE1317
119	Hospital	UAI Medical Admissions - Hospital Code	DE1318
120	Nursing Facility	UAI Medical Admissions - Nursing Facility Code	DE1319
121	Adult Care Residence	UAI Medical Admissions - Adult Care Residence Code	DE1320
122	Living Will	UAI Advanced Directives - Living Will Code	DE1321
123	Durable Power of Attorney for Health Care	UAI Advanced Directives - Durable Power of Attorney for Health Care Code	DE1322
124	Other	UAI Advanced Directives - Other Code	DE1323
125	Short-Term Memory Loss	UAI Cognitive Function - Short Term Memory Loss Code	DE1324
126	Long-Term Memory Loss	UAI Cognitive Function - Long Term Memory Loss Code	DE1325
127	Judgement Problem	UAI Cognitive Function - Judgment Problem Code	DE1326
128	MMSE Score	UAI Cognitive Function - MMSE Score	DE1327
129	Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems	UAI Alcohol, Drug Use Hospitalization Code	DE1328
130	Where does the caregiver live	UAI Informal Caregiver Proximity (Live) Code	DE1329
131	Has providing care to the client become a burden for the caregiver	UAI Informal Caregiver Patient Burden on Caregiver Code	DE1330

Input Forms AS-I-100 Provider Facility Ownership Change Form

General Information

This form is used to update the Enrollee and Assessment databases to Reflect a Change of Ownership of a Provider Facility including Nursing Home and Community Based Care facilities. The form is prepared by the DMAS Provider Unit and submitted to ACS Services (VMAP) QC Unit for entry of data into the MMIS.

Subsystem:	Financial
Source/Originator:	DMAS
Frequency:	On-Demand
Estimated Volume:	N/A
Programs:	Provider Change - Level of Care & Assessments (ASR400)
Proc/Screen ID:	RF-S-016-02

Provider Facility Ownership Change Form (AS-I-100)

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER FACILITY OWNERSHIP CHANGE FORM (AS-I-100)

DATE: _____ (1) REQUESTOR: _____ (2)

	(3) NEW PROVIDER	(4) PROV TYPE	(5) SITE IND	(6) OLD PROVIDER	(7) PROV TYPE	(8) SITE IND	(9) ADMISSION DATE	(10) EXCEPTION INDICATOR
REQUEST 1	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 2	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 3	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 4	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 5	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 6	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 7	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 8	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 9	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_
REQUEST 10	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ _ _	_ _ _	_ _	_ _ _ _ _ _ _ _ MM DD CCYY	_

FHSC USE ONLY:

DATE RECEIVED: ____ (11) _____

DATE PROCESSED: ____ (12) _____

INITIAL: ____ (13) _____

Field Definitions

#	Field Name	Data Element Name	Element ID
1	DATE		DE0000
2	REQUESTOR		DE0000
3	NEW PROVIDER	National Provider Identifier	DE4700
4	NEW PROVIDER TYPE	Provider Type	DE4006
5	NEW PROVIDER SITE IND	NPI XREF Site Number	DE4143
6	OLD PROVIDER	National Provider Identifier	DE4700
7	OLD PROVIDER TYPE	Provider Type	DE4006
8	OLD PROVIDER SITE IND	NPI XREF Site Number	DE4143
9	ADMISSION DATE	Enrollee Benefit Enrollment Begin Date	DE3064
10	EXCEPTION IND	Benefit Plan Exception Indicator	DE3072
11	DATE RECEIVED		DE0000

12	DATE PROCESSED		DE0000
13	INITIAL		DE0000

Input Forms FN-I-001 HIPP Program Application

General Information

This input form is received from the Department of Social Services when a Medicaid enrollee has insurance available through an employer.

Subsystem:	Financial
Source/Originator:	DSS
Frequency:	Daily
Estimated Volume:	Variable
Programs:	HIPP Cost Evaluation Program (FNT011)
Proc/Screen ID:	FN-S-011

HIPP Program Application (FN-I-001)

HEALTH INSURANCE PREMIUM PAYMENT PROGRAM
APPLICATION

1. **Please fill out your name and address**

Your Name and Address	Social Security Number (7)
(1)_____	- -
(2)_____	
(3)_____	Telephone Number (8)
(4)_____	( )_____(home)
(5)_____(6)_____	( )_____(work)

2. **Please complete the following information regarding your employment, or the employment of the parent offering the group health plan.**

Your Employer's Name and Address	Employee Benefits Manager (15) (if available)
(9)_____	_____
(10)_____	
(11)_____	Telephone Number (16)
(12)_____	( )_____
(13)_____(14)_____	

3. **Employee's name and SSN # (if different from your own). (17)** _____ **(18)**_____

4. **Please complete the following information regarding your insurance. If you have more than one plan, please list.**

Insurance Company (19)_____	Insurance Company _____
Name of Plan _____	Name of Plan _____

5. **List all persons eligible for coverage under this policy.**

(20) Name	(21) Date of birth MM/DD/CCYY	(22) Relationship	Medicaid Covered		Applied
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	

Signature: _____ **Date Completed:** _____

For DSS Use Only		
	Case ID Number (23)_____	Worker ID# (24)_____
	New Case ☐ Redetermination ☐	Program Designation (25)_____
		Court-Ordered Absent Parent Case (26)____
		Major Illness Yes ☐ No ☐

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Name	Enrollee Full Name	DE3003
2	Address	Enrollee Additional Address Name	DE3114
3	Address	Enrollee Street Address	DE3115
4	Address	Enrollee City Name	DE3116
5	Address	Enrollee State Code	DE3117
6	Address	Enrollee ZIP Code	DE3118
7	Social Security Number	Enrollee Social Security Number (SSN)	DE3034
8	Telephone Number	Enrollee Telephone Number	DE3095
9	Employer's Name	Payee Name	DE9560
10	Employer's Address	Payee Additional Address Line	DE9513
11	Employer's Address	Payee Address Line	DE9512
12	Employer's Address	Payee City	DE9514
13	Employer's Address	Payee State	DE9518
14	Employer's Address	Payee Zip Code	DE9519
15	Employee Benefits Manager	Payee Contact Name	DE9566
16	Telephone Number	Payee Phone Number	DE9565
17	Employee's Name	HIPP Payee Sequence Number	DE9515
18	Employee's SSN #	HIPP SSN/FEIN Number	DE9517
19	Insurance Company	Payee Name	DE9560
20	Name	Enrollee Full Name	DE3003
21	Date of Birth	Enrollee Birth Date	DE3005
22	Relationship	Enrollee Relationship to Case Head Code	DE3480
23	Case ID Number	Case Identification Number	DE3043
24	Worker ID #	Case Worker Number	DE3431
25	Program Designation	Enrollee Eligibility Aid Category	DE3009
26	Court-Ordered Absent Parent Case	TPL Absent Parent Indicator	DE3721

Input Forms FN-I-002 HIV Premium Assistance Program Application

General Information

This input form is received from the Department of Social Services when an enrollee has HIV and insurance is available through an employer.

Subsystem:	Financial
Source/Originator:	DSS
Frequency:	Daily
Estimated Volume:	Variable
Programs:	HIPP Cost Evaluation Program (FNT011)
Proc/Screen ID:	FN-S-011

HIV Premium Assistance Program Application (FN-I-002)

HIV PREMIUM ASSISTANCE PROGRAM
APPLICATION

The information on this form will be used in determining eligibility for the HIV Health Insurance Premium Assistance Program. All questions must be completed, and the form must be signed by the applicant or the applicant's representative.

All information on this form will be maintained in the strictest confidence. It will not be disclosed without written consent from you or your representative.

To help us process the application as quickly as possible and avoid a break in coverage under your insurance plan, the following information *must* be submitted with the completed application form:

- Physician's Verification Form
- A copy of your insurance card
- A copy of your most recent pay stub or tax return

If you wish to enroll or are currently enrolled in an insurance plan, you are responsible for any premium payments until eligibility is determined.

PART A – APPLICATION

Last Name (1)	First Name (2)	MI (3)
☐ Mr. ☐ Mrs. ☐ Ms.		

Your Address (4)	City (5)	State (6)	ZIP (7)

Telephone Number (8)	Date of Birth (9)	Sex (10)	Currently Enrolled in Medicaid
Home: ( ) Work: ( )	MM/DD/CCYY	☐ M ☐ F	☐ Yes ☐ No

Race (for statistical purposes only)	Virginia Resident	United States Citizen
	☐ Yes ☐ No	☐ Yes ☐ No

PART B – INSURANCE

Name of Insurance Company (11)	Policyholder Name (12)

Address of Insurance Company (13)	City (14)	State (15)	ZIP (16)

Effective Date of Policy (17)	Type of Coverage (18)	Total Number on Policy:	Copy of insurance Card attached?
MM/DD/CCYY	☐ Employee Only ☐ Family Other (explain)		

Monthly Premiums (19)	Date eligibility began, or will become effective: (20)
$	MM/DD/CCYY

HIV Premium Assistance Program Application (FN-I-002)

PART C – EMPLOYER INFORMATION

Employer providing coverage:
(21)_____
Address:
(22)_____
(23)_____
(24)_____**(25)**_____**(26)**_____

Contact (Group Administrator) (27)
_____

Phone #: (28)
( )_____

PART D – INCOME AND ASSET STATEMENT

INCOME	ASSETS
Please list the following family sources of income on an annual basis:	**Total family assets** _____
Wages _____ **(29)**	**Savings accounts** _____
Commissions and fees _____	**Checking accounts** _____
Salaries and tips _____	**Money market certificates** _____
Profit from self-employment _____	**Certificates of deposit** _____
Dividends or interest income _____	**Mutual funds** _____
Disability benefits _____	**Stocks and bonds** _____
Unemployment _____	
Pension or retirement _____	
Other (describe) _____	
Total: (cannot exceed 200% of federal poverty guidelines)	**Total: (cannot exceed 10,000)**

Please note: all income and asset information is subject to further verification.

READ CAREFULLY BEFORE SIGNING

- *I assume full responsibility for the accuracy of the statements on this form. I understand that the Department of Medical Assistance Services will use these statements to determine my eligibility for the HIV Health Insurance Premium Assistance Program.*
- *I understand that I am to reimburse the Department for any money received by me or paid on my behalf to which I was not entitled.*
- *I understand that if available funding is obligated, my name will be placed on a waiting list for three months. If I am still interested in the program after that time, it is my responsibility to reapply to the program.*
- *I agree to report any changes in my circumstances to the HIV Health Insurance Premium Assistance Program within 10 days, including changes in income, resources, employment, coverage, premium amount, and my address.*
- *I am aware that Virginia Laws provide that anyone who obtains or tries to obtain or who helps any person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the State of Virginia, including the Code of Virginia Sections 32.1-321.2 through 321.4 and 63.1-124.*
- *A copy of the HIV Health Insurance Premium Assistance Program policies has been provided to me. By my signature below, I certify I have read and understand these policies and agree to be bound by them for purposes of my application for and/or receipt of benefits under this program.*

SIGNATURES

Under penalty of perjury, I certify that the statements I have made are true and correct to the best of my knowledge and belief.

Signature of the Applicant: _____ Date: _____

If the Applicant was assisted in filling out this application, name of preparer _____

Relationship to Applicant: _____ Organization: _____

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Last Name	Enrollee Last Name	DE3110
2	First Name	Enrollee First Name	DE3111
3	MI	Enrollee Middle Initial	DE3112
4	Your Address	Enrollee Street Address	DE3115

5	City	Enrollee City Name	DE3116
6	State	Enrollee State Code	DE3117
7	ZIP	Enrollee ZIP Code	DE3118
8	Telephone Number	Enrollee Telephone Number	DE3095
9	Date of Birth	Enrollee Birth Date	DE3005
10	Sex	Enrollee Sex Code	DE3007
11	Name of Insurance Company	Payee Name	DE9560
12	Policyholder Name	TPL Policyholder Last Name	DE3737
13	Address of Insurance Company	Payee Additional Address Line	DE9513
14	City	Payee City	DE9514
15	State	Payee State	DE9518
16	ZIP	Payee Zip Code	DE9519
17	Effective Date of Policy	TPL Policy Effective Date	DE3659
18	Type of Coverage	HIPP Plan Type Code	DE9535
19	Monthly Premiums	HIPP Premium Amount	DE9537
20	Date Eligibility Began	HIPP Open Enrollment From Date	DE9550
21	Employer Providing Coverage	Payee Name	DE9560
22	Address	Payee Additional Address Line	DE9513
23	Address	Payee Address Line	DE9512
24	Address	Payee City	DE9514
25	Address	Payee State	DE9518
26	Address	Payee Zip Code	DE9519
27	Contact (Group Administrator)	Payee Contact Name	DE9566
28	Phone #	Payee Phone Number	DE9565
29	Wages	Enrollee Gross Income	DE3035

Input Forms FN-I-003 HIPP Request for Check Stub Letter

General Information

This input form is received from the case-holder and can be used to update the HIPP Cost Evaluation or HIPP Payee Screens.

Subsystem:	Financial
Source/Originator:	Employee
Frequency:	Monthly
Estimated Volume:	Variable
Programs:	HIPP Payee Data Program (FNT012)
Proc/Screen ID:	FN-S-012

HIPP Request for Check Stub Letter (FN-I-003)

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM
REQUEST FOR COPY OF PAYCHECK STUB

QUESTIONS? CALL HIPP.
(800) 432-5924 (Long Distance) or
(804) 225-4236 (local) or FAX (804) 786-0973

EMPLOYEE NAME **(1)**
EMPLOYEE STREET ADDRESS **(2)**
EMPLOYEE STREET ADDRESS **(3)**
EMPLOYEE CITY **(4)**, STATE **(5)**, ZIP **(6)**

(7) MEDICAID #: **(8)** HIPP #:

1. In order to receive your health insurance premium payment check, please attach your most recent paycheck stub showing the deduction for your health insurance. This must be received in this office no later than the first of every month so you can receive your reimbursement check. Failure to do so will result in delay or loss of your HIPP payment.

2. Are there any changes in your employment, insurance premiums, address, etc.? If 'yes', please fill out the information below and return with the copy of your paycheck stub.

(9) EMPLOYEE: _____ **(10)** SSN: _____
(11) NEW EMPLOYER: _____ **(12)** EMPLOYER PHONE #: _____
(13) NEW INSURANCE COMPANY: _____
(14) NEW PREMIUM AMOUNT: _____
(15) NEW ADDRESS: _____

OTHER: _____

The Department of Medical Assistance Services pays insurance premiums on behalf of eligible persons. Failure to report any changes may result in underpayments, cancellation of coverage, incorrect processing of medical claims, retractions, or overpayments. If you have any changes in employment, insurance coverage, premiums, etc. that would affect these health insurance payments, please complete item 2 and mail this form as soon as possible to assure continued HIPP payments..

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Employee Name	HIPP Payee Sequence Number	DE9515
2	Employee Street Address	Payee Additional Address Line	DE9513
3	Employee Street Address	Payee Address Line	DE9512
4	Employee City	Payee City	DE9514
5	State	Payee State	DE9518

6	Zip	Payee Zip Code	DE9519
7	Medicaid #	Enrollee Permanent Identification Number	DE3093
8	HIPP #	HIPP File Number	DE9522
9	Employee	HIPP Payee Sequence Number	DE9515
10	SSN	HIPP SSN/FEIN Number	DE9517
11	New Employer	Payee Name	DE9560
12	Employer Phone #	Payee Phone Number	DE9565
13	New Insurance Company	Payee Name	DE9560
14	New Premium Amount	HIPP Premium Amount	DE9537
15	New Address	Enrollee Additional Address Name	DE3114

Input Forms FN-I-004 Employer Insurance Verification Form

General Information

This input form is received from employers and is used to gather the information required for paying premium payments.

Subsystem:	Financial
Source/Originator:	Employers
Frequency:	Daily
Estimated Volume:	Variable
Programs:	HIPP Payee Data Program (FNT012)
Proc/Screen ID:	FN-S-012

Employer Insurance Verification Form (FN-I-004)

Today's Date: _____
Date Due: _____
(10 days)

EMPLOYER INSURANCE VERIFICATION

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE

HIPP Program (Health Insurance Premium Payment)
600 E. Broad Street, Suite 1300
Richmond, VA 23219
(804)225-4236

The State of Virginia is considering paying the health insurance premium on behalf of the employee listed below, in accordance with Section 1906 of the Social Security Act. Any information provided on this form will remain confidential. In order to help us make a determination, **please return this form within 10 days**. A pre-addressed stamped envelope is enclosed for your convenience.

PART A – ELIGIBILITY

1. Employee Status ☐ full time ☐ part time
2. Is this employee eligible for coverage under your company's group health plan? ☐ yes ☐ no
   (if "no", reason: _____)
   (if "no", fill out PART B only and return)

PART B – MEMBERSHIP **Employee**	**SS#**	**Birthdate**	**Eligible for health Plan** ☐ yes ☐ no **Currently enrolled in plan** ☐ yes ☐ no

Dependents	**SS#**	**Birthdate**	**Relationship**	**Eligible for health plan**	**Currently enrolled in plan**
				☐ **Yes** ☐ **no**	☐ **Yes** ☐ **no**
				☐ **Yes** ☐ **no**	☐ **Yes** ☐ **no**
				☐ **Yes** ☐ **no**	☐ **Yes** ☐ **no**
				☐ **Yes** ☐ **no**	☐ **Yes** ☐ **no**
				☐ **Yes** ☐ **no**	☐ **Yes** ☐ **no**

PART C – COVERAGE

1. If the employee is currently enrolled, what is the type of coverage?

   ☐ **Employee Only** ☐ **Employee Plus Child** ☐ **Family**

   Effective Date _____

2. If the employee is not currently enrolled, when can enrollment occur? **(1)**

   ☐ **Open Enrollment Dates: From** MM/DD/CCYY **To** MM/DD/CCYY
   ☐ **After Employment period is met (date eligible** _____**)**
   ☐ **Any time**

Employer Insurance Verification Form (FN-I-004)

PART D – PLAN BENEFITS

Please indicate benefits for each group health plan available to the employee. If more than 2 plans are available, use additional forms.

Name and Address of Insurance Company
(2)
(3)
(4) **(5)** **(6)**

Name of Plan _____

Premium Information
(employee's portion only)

(7) Coverage (please fill out all plans)	**(8) Premium Amount**	**(9) How Often**
Employee Only	$_____	☐ Weekly
Employee + Child	$_____	☐ Every Two Weeks
Family	$_____	☐ Monthly ☐ Quarterly

Type of Plan: **(10)**
☐ HMO ☐ PPO
☐ Hospital Only ☐ Comprehensive/ Major Medical

Services Covered: **(11)**
☐ Inpatient Hospital
☐ Outpatient Hospital
☐ Physicians ☐ Home Health
☐ Lab/Xray
☐ Drugs ☐ Dental

	(12)	
Pre-existing conditions excluded?	☐ Yes	☐ No
Dependent maternity excluded?	☐ Yes	☐ No
Waiting period for maternity?	☐ Yes	☐ No
How long _____		

Name and Address of Insurance Company
_____
_____
_____

Name of Plan _____

Premium Information
(employee's portion only)

Coverage (please fill out all plans)	**Premium Amount**	**How Often**
Employee Only	$_____	☐ Weekly
Employee + Child	$_____	☐ Every Two Weeks
Family	$_____	☐ Monthly ☐ Quarterly

Type of Plan:
☐ HMO ☐ PPO
☐ Hospital Only ☐ Comprehensive/ Major Medical

Services Covered:
☐ Inpatient Hospital
☐ Outpatient Hospital
☐ Physicians ☐ Home Health
☐ Lab/Xray
☐ Drugs ☐ Dental

Pre-existing conditions excluded?	☐ Yes	☐ No
Dependent maternity excluded?	☐ Yes	☐ No
Waiting period for maternity?	☐ Yes	☐ No
How long _____		

PART E – EMPLOYER'S REPRESENTATIVE: I hereby certify that all information contained herein is true and is correct to the best of my knowledge.

Group Administrator for Health Insurance Plan **(13)**_____
Employer **(14)**_____
Employer's Address **(15)**_____ **(16)**_____ **(17)**_____ **(18)**_____
Department _____
Phone # (____) _____ **(19)**

Signature _____ **Date** _____
Attach business card if available

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Open Enrollment	HIPP Open Enrollment From Date	DE9550
2	Name of Insurance Company	Payee Name	DE9560

3	Address of Insurance Company	Payee Additional Address Line	DE9513
4	Address of Insurance Company	Payee City	DE9514
5	Address of Insurance Company	Payee State	DE9518
6	Address of Insurance Company	Payee Zip Code	DE9519
7	Coverage	HIPP Plan Type Code	DE9535
8	Premium Amount	HIPP Premium Amount	DE9537
9	How Often	HIPP Payment Frequency Code	DE9538
10	Type of Plan	HIPP Plan Type Code	DE9535
11	Services Covered	TPL Code	DE5422
12	Pre-Existing	HIPP Medical Condition Indicator	DE9536
13	Group Administrator	Payee Contact Name	DE9566
14	Employer	Payee Name	DE9560
15	Employer's Address	Payee Additional Address Line	DE9513
16	Employer's Address	Payee City	DE9514
17	Employer's Address	Payee State	DE9518
18	Employer's Address	Payee Zip Code	DE9519
19	Phone #	Payee Phone Number	DE9565

Input Forms FN-I-005 Recoupment, Cash Receipt and Payment Add Pay/Recovery Transactions

General Information

This form is used as an input document and audit trail for the on-line Add Pay/Recovery process. This form has reason codes in the 1000, 2000, 8000 and 9000 ranges listed on it. The reason codes in the 1000 range are for setting up a recoupment. The reason codes in the 2000 range are for decreasing a recoupment. The reason codes in the 8000 range are for cash receipts. The reason codes in the 9000 range are for payments.

Subsystem:	Financial
Source/Originator:	DMAS Financial
Frequency:	On-Demand
Estimated Volume:	600 Per Month
Programs:	Capitation Payments Converted to Claims Report (FNW032)
Proc/Screen ID:	FN-S-006, FN-S-007

Recoupment, Cash Receipt and Payment Add Pay/Recovery Transactions (FN-I-005)

RECOUPMENTS, CASH RECEIPTS AND PAYMENTS

FCN: _____ (1) MATCHING FCN: _____ (2)

PAYEE ID: _____ (3) PAYEE NAME: _____ (4)

REASON CODES (5)

RECOUPMENT INCREASE/CLAIM RETRACTIONS (ACCOUNTS RECEIVABLE INCREASE)
_____ (1000 - 1999)

RECOUPMENT DECREASE (FIRST HEALTH RECEIVABLE)
_____ (2000 - 2999)

CASH RECEIPT
_____ (8000 - 8999)

PAYMENTS
_____ (9000 - 9999)

TRANSACTION AMOUNT: _____(6)_____ CHECK NUMBER: _____(7)_____

CHECK DATE: _____(8)_____ HH/DD/CCYY

BEGIN DATE: _____(9)_____ HH/DD/CCYY END DATE: _____(10)_____ HH/DD/CCYY

RECOUPMENT LIMIT: _____(11)_____ (Percentage) RECOUPMENT LIMIT: _____(12)_____ (Amount)

FISCAL YEAR: _____(13)_____ CCYY PROGRAM CODE: _____(14)_____

CLAIMS REF. NUMBERS: _____(15)_____ RECEIPT AMOUNTS: _____(16)_____

OBJECT CODE: _____ (17) FIPS CODE: _____ (18) FUND/FUND DETAIL: _____ (19, 20) FUND SPLIT(%) _____ (21)

BENEFIT PROGRAM CODE: _____ (22)

COMMENTS: _____ (23)

AUTH SIGNATURE _____ (24) _____ DATE: ____/__(25)__/____ (HH/DD/CCYY)

ENTERED: DATE _____ (26) TIME _____ (27) INITIALS _____ (28)

Field Definitions

#	Field Name	Data Element Name	Element ID
1	FCN	Financial Control Number	DE9874
3	Payee ID	Remittance Payee Identification Number	DE9588

4	Payee Name	Remittance Payee Name	DE9589
5	Reason Codes	Adjustment Reason Code	DE9877
6	Transaction Amount	Financial Amount	DE9817
7	Check Number	Financial Incoming Check Number	DE9807
8	Check Date	Financial Incoming Check Date	DE9806
9	Begin Date	Financial Begin Date	DE9804
10	End Date	Financial End Date	DE9811
11	Recoupment Limit	Financial Recoupment Limit (Percent)	DE9819
12	Recoupment Limit	Financial Recoupment Limit	DE9820
13	Fiscal Year	Budget Fiscal Year	DE9876
14	Program Code	Budget Program Code	DE9835
15	Claims Ref. Numbers	Claim Request ICN	DE2001
16	Receipt Amounts	Financial Receipt Amount	DE9812
17	Object Code	Budget Object Code	DE9843
18	FIPS Code	MMIS Locality Code based on Postal Code	DE5254
19	Fund	Budget Fund Code	DE9831
20	Fund Detail	Budget Fund Detail Code	DE9833
21	Fund Split	Budget Fund Split Percentage	DE9848
22	Benefit Program Code	Benefit Definition Plan Program Code	DE3551
23	Comments	Financial Comment Text	DE9809
24	Auth Signature		DE0000
25	Date		DE0000
26	Date		DE0000
27	Time		DE0000
28	Initials		DE0000

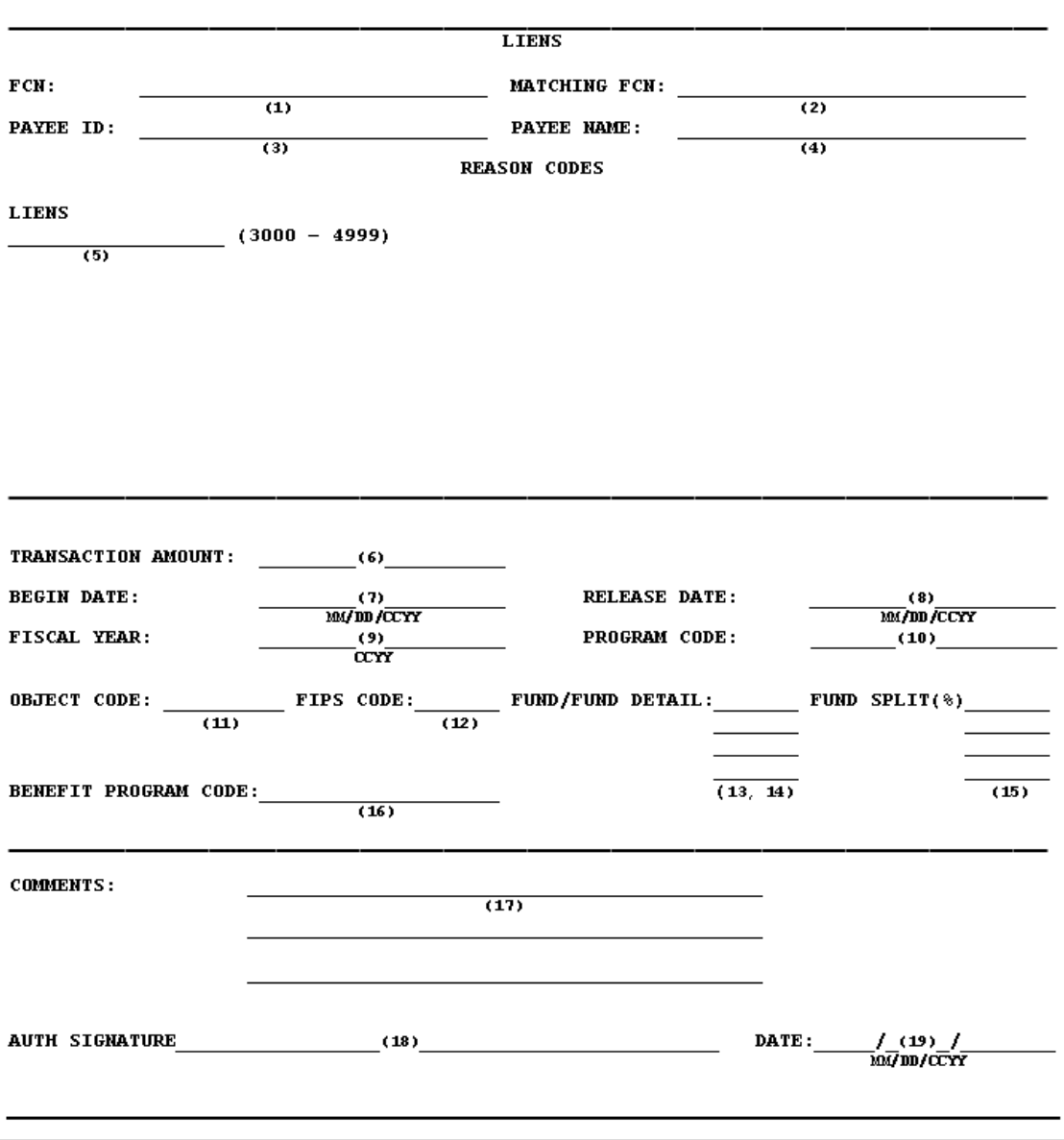
Input Forms FN-I-006 Lien Add Pay/Recovery Transactions

General Information

This form is used as an input document and audit trail for the on-line Add Pay/Recovery process. This form has reason codes in the 3000 and 4000 ranges listed on it. The reason codes in the 3000 range are for setting up a lien. The reason codes in the 4000 range are for releasing a lien.

Subsystem:	Financial
Source/Originator:	DMAS Financial
Frequency:	On-Demand
Estimated Volume:	600 Per Month
Programs:	Administrative Fees Converted to Claims Report (FNW031)
Proc/Screen ID:	FN-S-006, FN-S-007

Lien Add Pay/Recovery Transactions (FN-I-006)



Field Definitions

#	Field Name	Data Element Name	Element ID
1	FCN	Financial Control Number	DE9874
3	Payee ID	Remittance Payee Identification Number	DE9588
4	Payee Name	Remittance Payee Name	DE9589
5	Reason Codes	Adjustment Reason Code	DE9877
6	Transaction Amount	Financial Amount	DE9817
7	Begin Date	Financial Begin Date	DE9804
8	Release Date	Financial Release Date	DE9822

9	Fiscal Year	Budget Fiscal Year	DE9876
10	Program Code	Budget Program Code	DE9835
11	Object Code	Budget Object Code	DE9843
12	FIPS Code	MMIS Locality Code based on Postal Code	DE5254
13	Fund	Budget Fund Code	DE9831
14	Fund Detail	Budget Fund Detail Code	DE9833
15	Fund Split	Budget Fund Split Percentage	DE9848
16	Benefit Program Code	Benefit Definition Plan Program Code	DE3551
17	Comments	Financial Comment Text	DE9809
18	Auth Signature		DE0000
19	Date		DE0000

Input Forms FN-I-007 Hold Payment Add Pay/Recovery Transactions

General Information

This form is used as an input document and audit trail for the on-line Add Pay/Recovery process. This form has reason codes in the 5000 range listed on it. The reason codes in the 5000 range are for holding payments.

Subsystem:	Financial
Source/Originator:	DMAS Financial
Frequency:	On-Demand
Estimated Volume:	600 Per Month
Programs:	N/A
Proc/Screen ID:	FN-S-006, FN-S-007

Hold Payment Add Pay/Recovery Transactions (FN-I-007)

INPUT FORM FN-I-007 Hold Payments

HOLD PAYMENTS

FCN: _____ *MATCHING FCN:* _____

(1) (2)

PAYEE ID: _____1234567890_____ *PAYEE NAME:* _____

(3) (4)

REASON CODES

HOLD PAYMENTS

_____ (5000 - 5999)
(5)

BEGIN DATE (6) MM/DD/CCYY	END DATE (7) MM/DD/CCYY	BILLING ID (8)	PROVIDER TYPE (9)	TYPE OF SERVICE (10)	PROGRAM CODE (11)	DATES OF SERVICE FROM (12) MM/DD/CCYY	DATES OF SERVICE THROUGH (13) MM/DD/CCYY	ENROLLEE ID (14)
		1234567890						
		1234567890						
		1234567890						
		1234567890						
		1234567890						

BEGIN DATE ___(15)___ MM/DD/CCYY	END DATE ____(16)_____ MM/DD/CCYY	Servicing PROVIDER _____(17)_____	PAYMENT HOLD PERCENTAGE ____(18)___
		_1234567890____	
		_1234567890____	
		_1234567890____	
		_1234567890____	
		_1234567890____	

COMMENTS: _____
(19)
_____
_____

AUTH SIGNATURE_____(20)_____ **DATE:**_____/_(21)_/_____
MM/DD/CCYY

_____

Field Definitions

#	Field Name	Data Element Name	Element ID
1	FCN	Financial Control Number	DE9874
3	Payee ID	Remittance Payee Identification Number	DE9588
4	Payee Name	Remittance Payee Name	DE9589

5	Reason Codes	Adjustment Reason Code	DE9877
6	Begin Date	Financial Begin Date	DE9804
7	End Date	Financial End Date	DE9811
8	Billing Id	National Provider Identifier	DE4700
9	Provider Type	Provider Type	DE4006
10	Type Of Service	Claim Type of Service	DE2072
11	Program Code	Budget Program Code	DE9835
12	Dates Of Service From	Claim Service From Date	DE2010
13	Dates Of Service Thru	Claim Service Thru Date	DE2011
14	Enrollee ID	Enrollee Identification Number	DE3001
15	Begin Date	Financial Begin Date	DE9804
16	End Date	Financial End Date	DE9811
17	Servicing Provider	National Provider Identifier	DE4700
18	Payment Hold Percentage	Financial Hold Payment (Per-centage)	DE9818
19	Comments		DE0000
20	Auth Signature		DE0000
21	Date		DE0000

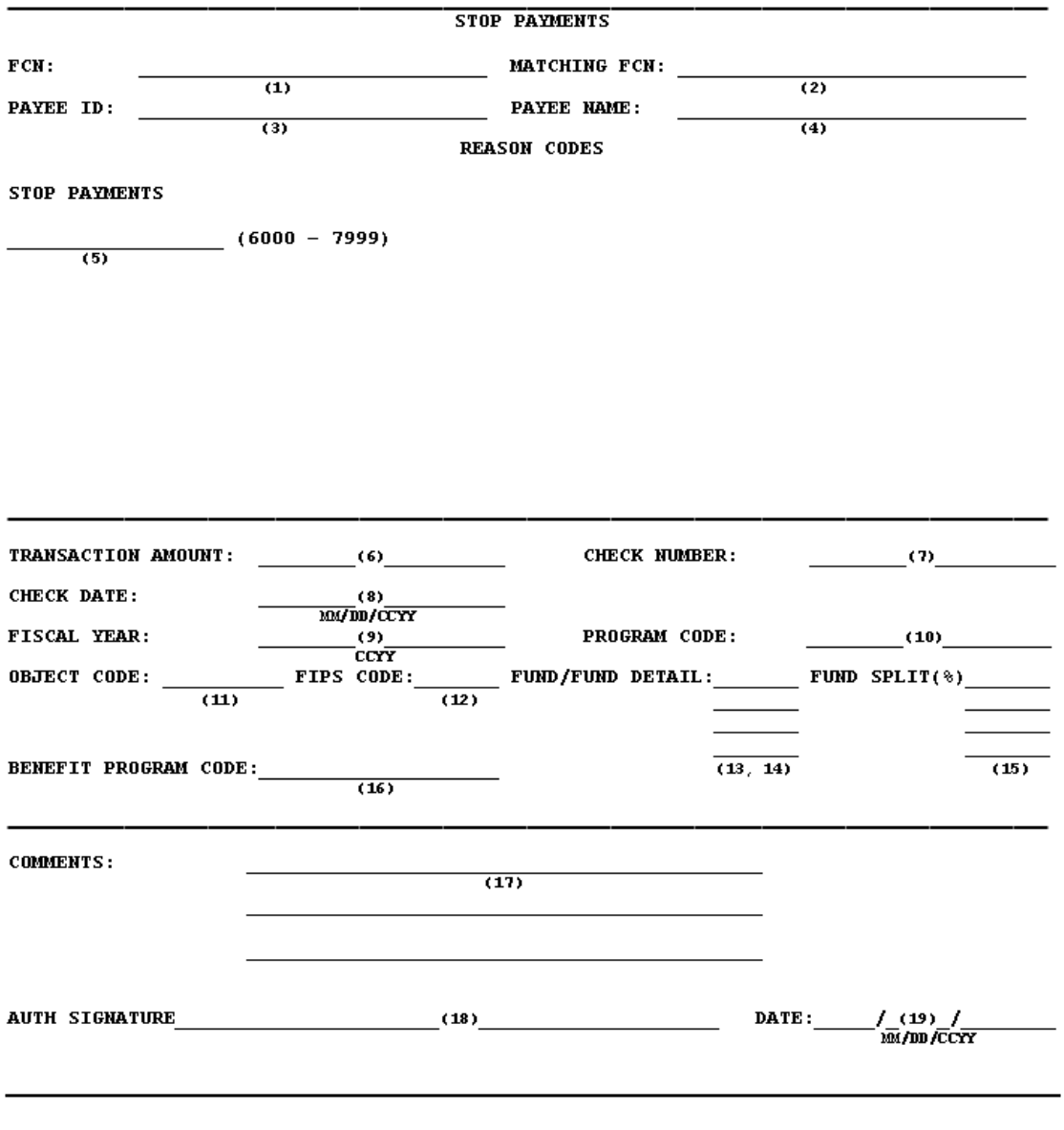
Input Forms FN-I-008 Stop Payment Add Pay/Recovery Transactions

General Information

This form is used as an input document and audit trail for the on-line Add Pay/Recovery process. This form has reason codes in the 6000 and 7000 ranges listed on it. The reason codes in the 6000 and 7000 ranges are for stopping payments.

Subsystem:	Financial
Source/Originator:	DMAS Financial
Frequency:	On-Demand
Estimated Volume:	600 Per Month
Programs:	N/A
Proc/Screen ID:	FN-S-006, FN-S-007

Stop Payment Add Pay/Recovery Transactions (FN-I-008)



Field Definitions

#	Field Name	Data Element Name	Element ID
1	FCN	Financial Control Number	DE9874
3	Payee Name	Remittance Payee Name	DE9589
4	Payee ID	Remittance Payee Identification Number	DE9588
5	Reason Codes	Adjustment Reason Code	DE9877
6	Transaction Amount	Financial Amount	DE9817
7	Check Number	Remittance Check Number	DE9576

8	Check Date	Remittance Payment Date	DE9578
9	Fiscal Year	Budget Fiscal Year	DE9876
10	Program Code	Budget Program Code	DE9835
11	Object Code	Budget Object Code	DE9843
12	FIPS Code	MMIS Locality Code based on Postal Code	DE5254
13	Fund	Budget Fund Code	DE9831
14	Fund Detail Code	Budget Fund Detail Code	DE9833
15	Fund Split	Budget Fund Split Percentage	DE9848
16	Benefit Program Code	Benefit Definition Plan Program Code	DE3551
17	Comments	Financial Comment Text	DE9809
18	Auth Signature		DE0000
19	Date		DE0000

Input Forms FN-I-009 Premium Payment Add Pay/Recovery Transactions

General Information

This form is used as an input form the Premium Payment Screen (FN-S-009). The form in conjunction with the screen will allow DMAS to create premium payment transactions that are a lump sum total. Individual premium payments are generated in the HIPP process.

Subsystem:	Financial
Source/Originator:	DMAS Financial
Frequency:	Monthly
Estimated Volume:	1 per month
Programs:	Premium Payment Request Update (FNT017)
Proc/Screen ID:	FN-S-009

Premium Payment Add Pay/Recovery Transactions (FN-I-009)

PREMIUM PAYMENT REQUEST

(1) PAYEE ID	(2) REASON CODE	(3) OBJECT CODE	(4) DESCRIPTION	(5) AMOUNT	(6) UNITS
XXXXXXXXX	XXXX	123720	Medicare Premiums,Part B,SLMB(120-134%) QI1		
XXXXXXXXX	XXXX	123701	Medicare Premiums, Categorically Needy,Part A		
XXXXXXXXX	XXXX	123702	Medicare Premiums, Categorically Needy,Part B		
XXXXXXXXX	XXXX	123703	Medicare Premiums, Medically Needy,Part B		

Authorized Signature: _____ (7) **DATE:** _____ (8) MM/DD/CCYY

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Payee ID	Remittance Payee Identification Number	DE9588
2	Reason Code	Adjustment Reason Code	DE9877
3	Object Code	Budget Object Code	DE9843
4	Description	Budget Object Code Description	DE9844
5	Amount	Financial Amount	DE9817
6	Units	Premium Payment Units	DE9888
7	Authorized Signature		DE0000
8	Date		DE0000

Input Forms FN-I-010 HIPP/HIV Paper Files

General Information

The HIPP/HIV Paper Files contain the manually collected data required to perform cost evaluation calculations. It also contains data required to link the dependents to a case.

Subsystem:	Financial
Source/Originator:	Operator
Frequency:	N/A
Estimated Volume:	Variable
Programs:	N/A
Proc/Screen ID:	FN-S-024

HIPP/HIV Paper Files (FN-I-010)

FNR109 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
AS OF: MM/DD/CCYY HIPP/HIV CASES CONVERSION REPORT
RUN DATE: MM/DD/CCYY HH:MM PAPER FILES INPUT FORM - FN-I-010

(1) (2)
CASE NAME: XXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX
(3) (4) (5)
HIPP #: 9999999 PREM TYPE: X CASE #: _____
(6) (7) (8) (9) (10)
PREM AMT: _____ PLAN TYPE: ____ FREQ: ___ # WEEKS: ___ # MONTHS: ___

(11)
ENROLLEE ID(S):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

*** END OF REPORT ***

HIPP/HIV Paper Files (FN-I-010)

```
FNR109                                  VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
AS OF:    MM/DD/CCYY                            HIPP/HIV CASES CONVERSION REPORT
RUN DATE: MM/DD/CCYY HH:MM                HIV PAPER FILES INPUT FORM - FN-I-010

 (1)                              (2)
CASE NAME:  XXXXXXXXXXXXXXXXXX XXXXXXXXXXX
 (3)              (4)                    (11)                 (32)
HIPP #: 9999999  PREM TYPE:  X  ENROLLEE ID: _______________  SSN: ___________
 (6)                 (7)            (8)              (9)          (10)
PREM AMT: __________ PLAN TYPE: ____ FREQUENCY: ___ # WEEKS: ___ # MONTHS: ___
 (12)                          (13)         (14)                 (15)
ELIG BEGIN DATE: _____________ RACE: ____ DOB: _____________ LANGUAGE: ____
 (16)                                      (17)
ENROLLEE ADDR1: _____________________ ENROLLEE ADDR2: _____________________
 (18)                                (19)          (20)
ENROLLEE CITY: _____________________ STATE: _____ ZIP: ___________________
 (21)                                    (22)
EMPLOYMENT BEGIN DATE: _____________  EMPLOYMENT END DATE: _____________
 (23)                                    (24)
EMPLOYER NAME: _____________________ CONTACT NAME: _____________________
 (25)
EMPLOYER ADDRESS: ___________________________________________________________
 (26)                                (27)          (28)
EMPLOYER CITY: _____________________ STATE: _____ ZIP: ___________________
 (29)                              (30)                 (31)
EMPLOYER PHONE #: _____________ GROSS INCOME: __________ HRS WORKED: _____


                                                *** END OF REPORT ***
```

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Case First Name	Enrollee Last Name	DE3110
2	Case Last Name	Enrollee First Name	DE3111
3	HIPP #	HIPP File Number	DE9522
4	Prem Type	HIPP Program Indicator	DE9507
5	Case #	Case Identification Number	DE3043
6	Prem Amt	HIPP Premium Amount	DE9537
7	Plan Type	HIPP Plan Type Code	DE9535
8	Freq	HIPP Payment Frequency Code	DE9538
9	# Weeks	HIPP Payment Weeks	DE9534
10	# Months	HIPP Payment Months	DE9533
11	Enrollee ID(S)	Enrollee Permanent Identification Number	DE3093
12	Elig Begin Date	Enrollee Eligibility Begin Date	DE3010

13	Race	Enrollee Race Code	DE3006
14	DOB	Enrollee Birth Date	DE3005
15	Language	Enrollee Primary Language Code	DE3476
16	Enrollee Addr1	Enrollee Additional Address Name	DE3114
17	Enrollee Addr2	Enrollee Street Address	DE3115
18	Enrollee City	Enrollee City Name	DE3116
19	State	Enrollee State Code	DE3117
20	Zip	Enrollee ZIP Code	DE3118
21	Employment Begin Date	Person Employer Begin Date	DE3944
22	Employment End Date	Person Employer End Date	DE3945
23	Employer Name	Employer Name	DE3170
24	Contact Name	Employer Contact Name	DE3178
25	Employer Address	Employer Address Line	DE3172
26	Employer City	Employer City Name	DE3173
27	State	Employer State Code	DE3174
28	Zip	Employer ZIP Code	DE3175
29	Employer Phone #	Employer Phone Number	DE3177
30	Gross Income	Enrollee Gross Income	DE3035
31	Hrs Worked	Enrollee Monthly Number of Hours Worked	DE3475
32	SSN	Enrollee Social Security Number (SSN)	DE3034
33	DSS Worker	Case Worker Number	DE3431
34	DSS FIPS	Case Administrative FIPS Code	DE3039
35	Enrollee FIPS	Enrollee FIPS Code	DE3008

Input Forms TP-I-001 Third Party Reporting Form

General Information

This form is used to update the TPL Resource and/or Carrier Files with third party liability information.

Subsystem:	Financial
Source/Originator:	DMAS
Frequency:	Daily
Estimated Volume:	Variable
Programs:	TPL Carrier Name Inquiry Program (TPT202) TPL Carrier Detail Inquiry/Update Program (TPT204)
Proc/Screen ID:	TP-S-002, TP-S-003, TP-S-004

Third Party Reporting Form (TP-I-001)

Recipient ID (Medicaid #): (1)_____

Recipient Name: (2)_____

Insurance Company and Address: (3)_____

(4)_____ **(5)**_____

(6)_____ **(7)**_____ **(8)**_____

Policy Number: (9)_____

Group Number: (10)_____

Effective Dates: (11)_____

Subscriber: (12)_____ **13)**____ **(14)**_____

Employer Name and Address: (15)_____

(16)_____ **(17)**_____

(18)_____ **(19)**_____ **(20)**_____

Forward To: **TPL Unit/Fiscal and Accounting**
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

DMAS - 1000

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Recipient ID	Enrollee Permanent Identification Number	DE3093
2	Recipient Name	Enrollee Full Name	DE3003
3	Insurance Company	TPL Carrier Name	DE3673
4	Address (Additional Address Name)	TPL Carrier Additional Address Name	DE3674
5	Address (Address Line)	TPL Carrier Address Line	DE3675

6	Address (City)	TPL Carrier City Name	DE3676
7	Address (State)	TPL Carrier State Code	DE3677
8	Address (Zip Code)	TPL Carrier ZIP Code	DE3678
9	Policy Number	TPL Policy Number	DE3658
10	Group Number	TPL Group Number	DE3697
11	Effective Dates	TPL Policy Effective Date	DE3659
12	Subscriber (First)	TPL Policyholder First Name	DE3738
13	Subscriber (MI)	TPL Policyholder Middle Initial	DE3739
14	Subscriber (Last)	TPL Policyholder Last Name	DE3737
15	Employer Name	Employer Name	DE3170
16	Address (Additional Address Name)	Employer Additional Address Name	DE3171
17	Address (Address Line)	Employer Address Line	DE3172
18	Address (City)	Employer City Name	DE3173
19	Address (State)	Employer State Code	DE3174
20	Address (Zip Code)	Employer ZIP Code	DE3175

Input Forms TP-I-002 TPL Contractor Telephone Verification Form

General Information

This form is used to update the TPL Resource and/or Carrier files with third party liability information that the user receives over the telephone. All date fields will be changed to CCYYMMDD or MMDDCCYY formats.

Subsystem:	Financial
Source/Originator:	DMAS
Frequency:	Daily
Estimated Volume:	Variable
Programs:	TPL Carrier Name Inquiry Program (TPT202) TPL Carrier Detail Inquiry/Update Program (TPT204)
Proc/Screen ID:	TP-S-002, TP-S-003, TP-S-004

TPL Contractor Telephone Verification Form (TP-I-002)

Health Management Systems, Inc. (HMS)
Virginia Department of Medical Assistance Services (DMAS)
Project 812: Telephone Verification Form

Medicaid Recipient Information

MEDICAID ID NUMBER: **(1)**_____SSN: **(2)**_____-_____-_____

FIRST NAME: **(3)**_____ MI: **(4)**____ LAST NAME: **(5)**_____

DATE OF BIRTH: **(6)**_____/_____/_____

Third Party Insurance Information
Company Rep. Name: **(7)**_____ Phone **(8)** (___)_____

Insurance Company Name: **(9)**_____

Claims Office Phone Number: **(10)** (_____)_____

Claims Office Address:

(11)
(12)
(13) **(14)** **(15)**

Policy or Certificate Number: **(16)**_____

Policy Holder's Name: (First): **(17)**_____ (MI): **(18)**____ (Last): **(19)**_____

Policy Holder's Social Security Number: **(20)**_____-_____-_____

Gender **(21)**_____ DOB **(22)**_____/_____/_____

(23)		**(24)**	
Effective Date 1:	_____/_____/_____	Termination Date 1:	_____/_____/_____
Effective Date 2:	_____/_____/_____	Termination Date 2:	_____/_____/_____
Effective Date 3:	_____/_____/_____	Termination Date 3:	_____/_____/_____
Effective Date 4:	_____/_____/_____	Termination Date 4:	_____/_____/_____
Effective Date 5:	_____/_____/_____	Termination Date 5:	_____/_____/_____
Effective Date 6:	_____/_____/_____	Termination Date 6:	_____/_____/_____

Group Name (if possible): **(25)**_____

Group Number (if possible): **(26)**_____

(27)
Circle all Coverage: MajMed Hospital Rx Dental Vision LTC homecare
Hospice Mental-health Other (describe)_____

Rx Vendor and claims submission address: **(28)**_____**(29)(30)(31)(32)(33)**_____
LTC Vendor and claims submission address: **(34)**_____**(35)(36)(37)(38)(39)**_____
Mental Health Vendor and claims submission address: **(40)**_____**(41)(42)(43)(44)(45)**_____

Circle Plan Type: Managed Care *with* out-of-network benefit
Managed Care *without* out-of-network benefit
Indemnity Other (describe)_____

TPL Contractor Telephone Verification Form (TP-I-002)

Health Management Systems, Inc. (HMS)
Virginia Department of Medical Assistance Services (DMAS)
Project 812: Telephone Verification Form

Dependent Information (FN, MI, LN)

(46) (47) (48) (49) (50) (51) (52) (53)

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Name: _____, SSN_____-_____-_____,Rel___,Eff:___,Term:___,DOB___

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Medicaid ID Number	Enrollee Permanent Identification Number	DE3093
2	SSN	Enrollee Social Security Number (SSN)	DE3034
3	First Name	Enrollee First Name	DE3111
4	MI	Enrollee Middle Initial	DE3112
5	Last Name	Enrollee Last Name	DE3110
6	Date of Birth	Enrollee Birth Date	DE3005
7	Company Rep. Name	Employer Contact Name	DE3178
8	Phone	Employer Phone Number	DE3177
9	Insurance Company Name	TPL Carrier Billing Name	DE3709
10	Claims Office Phone Number	TPL Carrier Billing Telephone Number	DE3711
11	Claims Office Address (Additional Address Name)	TPL Carrier Billing Additional Address Name	DE3712
12	Claims Office Address (Address Line)	TPL Carrier Billing Address Line	DE3713

13	Claims Office Address (City)	TPL Carrier Billing City Name	DE3714
14	Claims Office Address (State)	TPL Carrier Billing State Code	DE3715
15	Claims Office Address (Zip Code)	TPL Carrier Billing ZIP Code	DE3716
16	Policy or Certificate Number	TPL Policy Number	DE3658
17	Policy Holder's Name (First)	TPL Policyholder First Name	DE3738
18	Policy Holder's Name (MI)	TPL Policyholder Middle Initial	DE3739
19	Policy Holder's Name (Last)	TPL Policyholder Last Name	DE3737
20	Policy Holder's Social Security Number	TPL Policy Holder Social Security Number (SSN)	DE3670
21	Gender	Enrollee Sex Code	DE3007
22	DOB	Enrollee Birth Date	DE3005
23	Effective Dates	TPL Policy Effective Date	DE3659
24	Termination Dates	TPL Policy End Date	DE3660
25	Group Name	TPL Group Name	DE3727
26	Group Number	TPL Group Number	DE3697
27	Coverage	TPL Coverage Code	DE3013
28	Rx Vendor	TPL Carrier Billing Name	DE3709
29	Rx Vendor Claims Submission Address (Additional Line)	TPL Carrier Billing Additional Address Name	DE3712
30	Rx Vendor Claims Submission Address (Address Line)	TPL Carrier Billing Address Line	DE3713
31	Rx Vendor Claims Submission Address (City)	TPL Carrier Billing City Name	DE3714
32	Rx Vendor Claims Submission Address (State)	TPL Carrier Billing State Code	DE3715
33	Rx Vendor Claims Submission Address (Zip Code)	TPL Carrier Billing ZIP Code	DE3716
34	LTC Vendor	TPL Carrier Billing Name	DE3709
35	LTC Vendor Claims Submission Address (Additional Line)	TPL Carrier Billing Additional Address Name	DE3712
36	LTC Vendor Claims Submission Address (Address Line)	TPL Carrier Billing Address Line	DE3713
37	LTC Vendor Claims Submission Address (City)	TPL Carrier Billing City Name	DE3714
38	LTC Vendor Claims Submission Address (State)	TPL Carrier Billing State Code	DE3715
39	LTC Vendor Claims Submission Address (Zip Code)	TPL Carrier Billing ZIP Code	DE3716
40	Mental Health Vendor	TPL Carrier Billing Name	DE3709
41	Mental Health Vendor Claims Submission Address 1	TPL Carrier Billing Additional Address Name	DE3712

42	Mental Health Vendor Claims Submission Address 2	TPL Carrier Billing Address Line	DE3713
43	Mental Health Vendor Claims Submission Address (City)	TPL Carrier Billing City Name	DE3714
44	Mental Health Vendor Claims Submission Address (State)	TPL Carrier Billing State Code	DE3715
45	Mental Health Vendor Claims Submission Address (Zip Code)	TPL Carrier Billing ZIP Code	DE3716
46	Dependent Name (First)	Enrollee First Name	DE3111
47	Dependent Name (MI)	Enrollee Middle Initial	DE3112
48	Dependent Name (Last)	Enrollee Last Name	DE3110
49	SSN	Enrollee Social Security Number (SSN)	DE3034
50	Rel	TPL Relationship Code	DE3704
51	Eff	TPL Policy Effective Date	DE3659
52	Term	TPL Policy End Date	DE3660
53	DOB	Enrollee Birth Date	DE3005

Input Forms TP-I-004 TPL Suspect/Verification Letter

General Information

This letter will be used to update the TPL Resource and/or Carrier Files with information received from the recipient or provider. Coverage effective and termination dates will be changed to CCYYMMDD format.

Subsystem:	Financial
Source/Originator:	DMAS
Frequency:	Daily
Estimated Volume:	Variable
Programs:	TPL Carrier Name Inquiry Program (TPT202) TPL Carrier Detail Inquiry/Update Program (TPT204)
Proc/Screen ID:	TP-S-002, TP-S-003, TP-S-004

TPL Suspect/Verification Letter (TP-I-004)

August 9, 1998

XYZ Company or John Doe
3928 Freeport Place
P.O. Box 2754
Glen Allen , VA 23058-2754

RE: John Doe
DMAS #: 999999999 **(1)**

DOB: 99/99/9999
SEX: XXXXXX

The Department of Medical Assistance Services (DMAS) has been notified that the above Medicaid recipient has insurance coverage through XYZ Company. Medicaid is a "last resort" program, governed and funded under state and Federal law. Verification of insurance information is needed to update our records in order to ensure that Medicaid pays after the other coverage limits have been utilized.

Please make necessary corrections and/or complete the information requested below.

Policy #: **(2)**_____

Group #: **(3)**_____

Insured #: **(4)**_____

Name of Claims Office: **(5)**_____

Telephone # of Claims Office: **(6)** (_____)_____

Address of Claims Office: **(7)**_____

(8)_____

(9)_____**(10)**_____**(11)**_____

Type of Policy: **(12)**_____

Type of Coverage: **(13)**_____

Coverage Effective Date: **(14)** _____

Coverage Termination Date: **(15)**_____

Pharmacy Benefit Manager: _____

Person & Phone # who completed form: _____

Please return response to:

Department of Medical Assistance Services
Attn: Third Party Liability Unit
600 East Broad Street/Suite 1300
Richmond, VA 23219

If assistance is needed in completing this form, please call 804-225-2990. Your assistance in helping to reduce Medicaid's cost will be greatly appreciated.

Thank You
Third Party Liability and Recovery Unit

Field Definitions

#	Field Name	Data Element Name	Element ID

1	DMAS #	Enrollee Permanent Identification Number	DE3093
2	Policy #	TPL Policy Number	DE3658
3	Group #	TPL Group Number	DE3697
4	Insured #	TPL Policy Holder Social Security Number (SSN)	DE3670
5	Name of Claims Office	TPL Carrier Billing Name	DE3709
6	Telephone # of Claims Office	TPL Carrier Billing Telephone Number	DE3711
7	Address of Claims Office (Additional Address)	TPL Carrier Billing Additional Address Name	DE3712
8	Address of Claims Office (Address Line)	TPL Carrier Billing Address Line	DE3713
9	Address of Claims Office (City)	TPL Carrier Billing City Name	DE3714
10	Address of Claims Office (State)	TPL Carrier Billing State Code	DE3715
11	Address of Claims Office (Zip Code)	TPL Carrier Billing ZIP Code	DE3716
12	Type of Policy	TPL Policy Type	DE3703
13	Type of Coverage	TPL Carrier Code	DE3657
14	Coverage Effective Date	TPL Policy Effective Date	DE3659
15	Coverage Termination Date	TPL Policy End Date	DE3660

Input Forms TP-I-005 TPL Incident Letter

General Information

This letter is used to update the TPL Resource and/or Carrier Files with third party liability information received from the recipient for non-recoveries. Recoveries will update the IRP Database on the TPLRS via the TPL Incident Screen.

Subsystem:	Financial
Source/Originator:	DMAS
Frequency:	Daily
Estimated Volume:	Variable
Programs:	TPL Carrier Name Inquiry Program (TPT202) TPL Carrier Detail Inquiry/Update Program (TPT204)
Proc/Screen ID:	TP-S-002, TP-S-003, TP-S-004

TPL Incident Letter (TP-I-005)

[redacted]

TPLA [redacted] 07/29/98

ROANOKE, VA
24018-1473

CITY/COUNTY CODE
CASEWORKER NUMBER [redacted]

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES HAS PAID FOR MEDICAL CARE YOU RECEIVED ON THE DATE (S) AND BY THE PROVIDER (S) LISTED BELOW.

IT IS NECESSARY TO DETERMINE IF AN INSURANCE COMPANY OR OTHER PERSON MAY BE RESPONSIBLE FOR PAYING THESE BILLS. PLEASE HELP US OBTAIN THE DETAILS OF THE INJURY BY COMPLETING THE REVERSE SIDE OF THIS LETTER ("THIRD PARTY LIABILITY INFORMATION REPORT").

A NEW LETTER REQUESTING INFORMATION REGARDING THIS INJURY WILL AUTO-MATICALLY BE GENERATED IN SUBSEQUENT MONTHS IF ADDITIONAL MEDICAL SERVICES ARE RECEIVED. IF YOU HAVE PREVIOUSLY RESPONDED BY COMPLETING THE "THIRD PARTY LIABILITY INFORMATION REPORT", PLEASE IGNORE ANY SUBSEQUENT REQUESTS YOU RECEIVE.

YOUR COOPERATION AND ASSISTANCE IN HELPING TO REDUCE MEDICAID'S COST WILL BE GREATLY APPRECIATED.

IF ASSISTANCE IS NEEDED IN COMPLETING THE FORM, PLEASE CONTACT YOUR CASEWORKER AT THE LOCAL SOCIAL SERVICE DEPARTMENT OR CALL 804/786-5458.

THANK YOU,
THIRD PARTY LIABILITY AND RECOVERY UNIT

TREATMENT DATE	TREATMENT RECEIVED	PROVIDER
06/29/98	[redacted]	

RECIPIENT TELEPHONE NUMBER (____)_____

TPL Incident Letter (TP-I-005)

THIRD PARTY LIABILITY INFORMATION REPORT

(PLEASE COMPLETE THIS FORM AND RETURN TO
THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
800 EAST BROAD ST. SUITE 13000
RICHMOND, VIRGINIA 23219

DATE OF ACCIDENT OR INJURY: (0.1)_____ TYPE OF ACCIDENT OR INJURY: _____
(WORK, AUTO, HOME, FALL, GUNSHOT, ETC.)

(IF YOU HAVE AN ATTORNEY REPRESENTING YOU FOR YOUR ACCIDENT OR INJURY, PLEASE COMPLETE THE FOLLOWING):

NAME OF RECIPIENT'S ATTORNEY (0.2)_____

MAILING ADDRESS: (0.3, 0.4, 0.5, 0.6., 0.7)_____

TELEPHONE NUMBER (0.8)_____

(IF YOU HAVE INSURANCE COVERAGE, ACCIDENT OR LIABILITY, PLEASE PROVIDE THE FOLLOWING):

NAME OF INSURANCE COMPANY **(1)**_____

ADDRESS **(2)**_____**(3)**_____**(4)**_____**(5)**_____**(6)**_____

POLICY NUMBER **(7)**_____ CLAIM NUMBER _____

(IF AN AUTO ACCIDENT, PLEASE COMPLETE THE FOLLOWING):

NAME OF OWNER OF AUTO _____

ADDRESS _____

INSURANCE CO. _____POLICY NO. _____CLAIM NO. _____

NAME OF DRIVER OF AUTO _____

ADDRESS _____

(FOR OTHER TYPES OF ACCIDENTS, PLEASE COMPLETE THE FOLLOWING):

LOCATION AND DESCRIPTION _____

FURTHER COMMENTS _____

_____ ____/____/____
SIGNATURE DATE

_____
RECIPIENT'S TELEPHONE NUMBER

Field Definitions

#	Field Name	Data Element Name	Element ID
0.1	Date of Injury	Enrollee Incident End Date	DE3084
0.2	Recipient's Attorney	TPL Incident Address Name	DE3883

0.3	Mailing Address	TPL Incident Address Line 1	DE3885
0.4	Mailing Address 2	TPL Incident Address Line 2	DE3886
0.5	City	TPL Incident Address City	DE3887
0.6	Zip	TPL Incident Address Zip Code	DE3889
0.7	State	TPL Incident Address State	DE3888
0.8	Telephone	TPL Incident Phone Number	DE3884
1	Name of Insurance Company	TPL Carrier Name	DE3673
2	Address (Additional Address Line)	TPL Carrier Additional Address Name	DE3674
3	Address (Address Line)	TPL Carrier Address Line	DE3675
4	Address (City)	TPL Carrier City Name	DE3676
5	Address (State)	TPL Carrier State Code	DE3677
6	Address (Zip Code)	TPL Carrier ZIP Code	DE3678
7	Policy Number	TPL Policy Number	DE3658